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CIS

ADMINISTRATION'S PROPOSED BUDGET CUTS AFFECTING THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

SECOND SESSION

MARCH 2 AND JUNE 15, 1982

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ADMINISTRATION'S PROPOSED BUDGET CUTS AFFECTING THE MEDICARE PROGRAM

TUESDAY, MARCH 2, 1982

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met at 10:05 a.m., pursuant to notice, in room 1100, Longworth House Office Building, Hon. Andy Jacobs (chairman of the subcommittee) presiding.

[Press release announcing the hearing follows:]

[Press Release of Feb. 17, 1982]

Hon. Andy Jacobs, Jr. (D., Ind.), Chairman, Subcommittee on Health of the Committee on Ways and Means, Announces Hearing on Proposed Budget Cuts

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a public hearing on Tuesday, March 2, 1982, to receive testimony on the Reagan Administration's proposed budget cuts in the medicare program. The hearing will begin at 10:00 a.m. in the Ways and Means Committee Main Hearing Room, 1100 Longworth House Office Building.

President Reagan has proposed reductions in medicare of $2.5 billion and increases in revenues of $619 million for fiscal year 1983. Of the $2.5 billion in medicare cuts, $1.8 billion would require legislative changes while $755 million represent proposed regulatory initiatives.

Legislative recommendations made by the Reagan Administration include, among others: indexing the medicare part B deductible, delaying the initial eligibility date for medicare beneficiaries, imposing a five percent copayment on home health services for the elderly and disabled, requiring employers with health benefit plans to cover employees who continue to work after age 65, reducing hospital cost reimbursement by 2 percent, delaying from July to October the annual update in the physician reimbursement schedule, and eliminating Professional Standards Review Organizations. In addition, the Administration is proposing to increase revenues by imposing the medicare portion of the social security tax on Federal employees. This would ultimately make Federal employees eligible for medicare.

Due to time restrictions, the hearing will be limited to testimony from the Administration and invited witnesses representing the interested public. At this time, the Subcommittee will hear testimony on the Reagan Administration's proposed reductions in the medicare program only for purposes of establishing spending levels for the First Budget Resolution. It is anticipated that additional public hearings will be held whenever the Subcommittee begins to consider legislative changes.

Any interested person or organization may file a written statement for inclusion in the printed record.

PROCEDURE TO BE FOLLOWED FOR SUBMITTING WRITTEN COMMENTS

Interested individuals and organizations may submit written comments, which should address only the above subject, through the close of business, Wednesday, March 10, 1982. Comments (3 copies) should be submitted to John J. Salmon, Chief Counsel, Committee on Ways and Means, 1102 Longworth House Office Building, Washington, D.C. 20515.

Chairman JACOBS. I think we are ready to begin the hearings.

The purpose of the hearing today is to put on the record the administration's proposal for budget changes, sometimes known as cuts, in the medicare program. There will be obviously a great deal of discussion about the proposals of the administration, and there is no better spokesperson for the administration than the Administratrix of the Health Care Financing Administration, Dr. Carolyne Davis.

Dr. Davis, as usual you are quite welcome, and we appreciate your contribution to the record. You may proceed according to the rules as you understand them.

STATEMENT OF CAROLYNE K. DAVIS, PH. D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION [HCFA], DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY KEVIN J. SEXTON, DIRECTOR, HCFA OFFICE OF MANAGEMENT AND BUDGET, PATRICE H. FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY, AND GEORGE SCHIEBER, DIRECTOR, OFFICE OF LEGISLATION AND POLICY ANALYSIS

Ms. DAVIS. Thank you very much, Mr. Chairman. I am pleased to be here today.

Let me introduce my colleagues. To my left is Patrice Hirsch Feinstein, who is the Associate Administrator for Policy, and to her left is George Schieber, the Director of the Office of Policy Analysis. On my right is Kevin Sexton, the Director of the Office of Management and Budget in HCFA.

About a year ago the Federal Government adopted a number of spending reforms, and I think it is even more imperative today that we utilize discipline in our Federal spending in order to further the goals of the President's economic recovery program.

Last year we began to control the inflationary cost of the federally financed portion of our health care system, and we believe that enactment of the President's fiscal year 1983 budget will further build on those reforms.

If we are not able to control rising health care costs, we simply may not be able to afford the services which all of us now take for granted. We recognize that health care costs in the past several years have indeed been growing faster than the general rate of inflation. In 1981 alone hospital costs rose at a rate that is nearly twice the general level of inflation, and in 1983 approximately two-thirds of the expected increase in medicare expenditures will be attributable to cost inflation.

The costs of the medicare program in 1981 were $42.5 billion, roughly a 21-percent increase over 1980. In 1982, medicare expenditures are projected to reach $49.8 billion for a 17-percent increase over last year. Two-thirds of the medicare benefits are for inpatient hospital care, and another fifth pays for physicians' services.

In 1980 the medicare hospital insurance trustees reported that even with the scheduled increases in the social security payroll tax, which of course finances the fund, that the hospital insurance trust fund could go broke shortly after 1990 unless measures are taken to reduce the rate of increase in program expenditures.

They now estimate that because of higher than originally estimated inflation in hospital costs that program outlays under current law may exceed income beginning in 1985. We, therefore, think that it is clear that both short-term action to reduce medicare expenditures and longer term structural changes are needed in order to insure that the medicare system does maintain a sound financial basis.

The medicare and medicaid programs have a leading role in the fight against inflation. We think this is particularly important, since medicare and medicaid comprise roughly 10 percent of the total Federal budget. In this regard the administration will soon submit to Congress legislative proposals that are going to be aimed at encouraging greater competition in the health care sector through the promotion of consumer choice.

Our fiscal year 1983 budget contains a series of proposals which will reform medicare coverage policy and reimbursement to providers while streamlining program administration. We believe that major savings resulting from these proposals can be derived through provisions that will affect reimbursement to hospitals and physicians, coordination with other insurance plans, and coverage of Federal employees under the part A.

Our 1983 medicare legislative and regulatory proposals when implemented, will hold expenditures next year to $2.5 billion below what they otherwise would have been. Yet, even with all of the medicare legislative and regulatory proposals that are included in our package, program expenditures in 1983 will still be $6 billion more than expected 1982 expenditures.

Now, let me briefly summarize some of the proposals that we have in the budget. First is a proposal to bring Federal employees under medicare part A. This will produce a revenue increase to the Federal budget of some $619 million in 1983, so that for the first time Federal workers would become eligible for medicare based on their Federal employment.

Most workers are subject to the hospital insurance tax throughout their entire career, yet the Federal employee can earn the same coverage with relatively fewer years of work that are subject to the tax. We estimate that between 60 and 80 percent of Federal annuitants over the age of 65 currently qualify for hospital insurance benefits based on either their own records in non-Federal employment or that of their spouse.

Another proposal is to modify medicare coverage of the working aged which would net a Federal savings of $303 million. Employers would be required to offer employees between the ages of 65 and 70 the same health benefits that are offered to their younger workers, and employers who would not offer these programs would not be permitted to claim the full cost of their health insurance as a tax deduction.

Medicare would pay for covered services after the private insurer had covered its share of the total cost. Since medicare is currently the first payer, we believe we have subsidized a substantial portion of the payroll costs for aged individuals who are now enrolled in employers' health plans.

In the area of medicare contracting, our budget request for the administrative costs of medicare carriers and intermediaries is at the same level as in 1982. This reflects our continuing efforts to implement program efficiencies, including such things as application of new automated data processing technology, and elimination of unnecessary contractor regulations and operating instructions and performance standards. We have already seen new technology being used in the private sector for paperless claims processing. We believe that these same kinds of innovations can allow the program to accommodate an increased workload without increasing administrative cost.

We are also proposing that HCFA be provided with additional administrative discretion regarding how intermediaries and carriers are chosen and the manner in which they are reimbursed. For example, we support the elimination of the nomination process and request authority from Congress to use alternatives to the current cost-based reimbursement, such as in areas of competitive bidding and fixed price or incentive arrangements in order to produce the most economical results without sacrificing the quality of services.

Another proposal would reduce medicare reimbursement to hospitals by 2 percent. Our savings from this would equal some $653 million in 1983. The decrease of two percent in reimbursable hospital costs would be of an interim nature, since we will continue to move forward on the development of prospective reimbursement methodologies, and also with the competitive proposals which I mentioned earlier.

This approach is broadly similar to the medicaid cost reductions that were adopted by Congress in the Omnibus Reconciliation Act of 1981, and it has the same goal: to reduce the rapid rate of increase in Federal health care expenditures.

We also proposed to limit the increase in the medicare economic index to 5 percent for a savings of $35 million in 1983. We would limit the rate of increase that would occur through the application of the medicare economic index formula to 5 percent rather than 7.8 percent for physician reimbursement. Medicare physician reimbursement per enrollee has risen some 17 percent in each of the last 2 years. This would be a one-time limit, and it would place a share of the burden of slowing the growth of our health care expenditures on physicians.

We are proposing that medicare reimburse for inpatient radiology and pathology services at 80 percent of reasonable charge. This would result in a savings of $160 million.

In 1967 the social security amendments authorized medicare to pay 100 percent of reasonable charges for inpatient services to radiologists and pathologists. This provision was intended to simplify reimbursement procedures and to streamline claims processing through combined billing for physicians' services and for hospital services. Yet, 75 percent of the radiologists and pathologists do not submit combined bills.

Furthermore, payment reviews are simply not possible under combined billing because the procedures cannot be separately identified. We are proposing to reimburse for these kinds of services in the same manner as we do all other physician services under medicare. We believe that this will assure that all physicians, regardless of their specialties, will be treated equitably.

We have a regulatory proposal which will save $160 million in 1983 by eliminating duplicate medicare payments for services in outpatient departments. Physicians who provide care in hospital outpatient departments are now paid at the same rate for medicare services as they would be in their private offices, even though the hospital in many cases is reimbursed separately for the overhead costs.

We, therefore, are proposing to refine the application of medicare's customary and prevailing charge screens to reflect more accurately allowable charges for professional services provided in different locations.

There are some 50 other major and technical proposals included in our budget, and I am simply going to highlight a few of those.

The Professional Standards Review Organizations (PSRO). As part of our administrative commitment to reduce the regulatory burden in the private sector we, once again, are proposing legislation to eliminate the requirements for PSRO review of medicare services. We anticipate that those PSRO's that have demonstrated their effectiveness will be able to continue operations by marketing their services in both the public and the private sectors.

We are also proposing to have medicare coverage for both hospital and supplemental medical insurance begin with the first day of the month following the month of an individual's 65th birthday rather than the first day of that month. We are proposing to index the part B deductible to the Consumer Price Index beginning in 1983.

Between 1972 and 1981 program expenditures increased approximately 250 percent, and yet there was no increase in the deductible amount until this Congress decided last year to raise it from $60 to $75.

Social security cash benefits are indexed to account for increases in the cost of living, and the part A deductible and coinsurance amounts are adjusted to reflect increases in program costs. In like fashion, we propose indexing of the deductible in order to keep its value constant. This proposal would save some $65 million.

We are proposing a required 5-percent coinsurance for all home health visits. This is a very small increase in cost sharing. We think it is reasonable and do not believe it would deter the use of necessary home health services. We also believe that it would act as a deterrent to unnecessary utilization. The savings from enactment of this proposal would total some $35 million.

We have a legislative proposal to extend the current medicare physician reimbursement fee screen year to September 30 of 1982 and to establish all future fee screens on the new fiscal year basis. Delaying the update for part B physician screens would save $210 million.

For institutional providers who furnish noncovered care to a medicare beneficiary, we are proposing that they no longer be free of liability for the cost of that care. We think it is imprudent for the Federal Government to pay for services that are found to be uncovered or unnecessary simply because providers have not yet become aware of medicare coverage rules. We think that by making the provider liable, it will give them an incentive to make themselves aware of those rules and to better manage admission and treatment policies.

We would continue to protect from liability those beneficiaries who were not aware that the services were not covered.

In closing, Mr. Chairman, I believe enactment of our 1983 proposals are essential to ensuring that the medicare program continues to meet the basic health care needs of our elderly and disabled while continuing to control the rapidly escalating cost of the program.

That concludes my statement.

[The prepared statement follows:]

STATEMENT OF CAROLYNE K. DAVIS, PH. D., ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION

INTRODUCTION

Mr. Chairman, I am pleased to be here to discuss the impact of the President's 1983 budget upon the Medicare program. With me today are Patrice Hirsch Feinstein, Associate Administrator for Policy, George Schieber, Director, Office of Legislation and Policy Analysis, and Kevin Sexton, Director, Office of Management and Budget. Medicare proposals in the budget have been developed in response to some of the critical problems in our health care system.

One year ago, the reality of inflation and the harm it was inflicting prompted the American people to demand that the Federal Government adopt spending reforms. It is even more imperative today that we utilize discipline in Federal spending to further the goals of the President's economic recovery program. Last year, with the enactment of the Omnibus Budget Reconciliation Act of 1981, we began together to control the inflationary costs of the Federally financed portion of our health care system. Enactment of the President's fiscal year 1983 budget will build further on those reforms. If we are not able to control rising health care costs, we may not be able to afford services which we now take for granted.

THE PROBLEMS

We all recognize that health care costs in the past several years have been growing faster than the general rate of inflation in the economy. In 1981 alone hospital costs rose at a rate nearly twice the general level of inflation. The continuing rise in health care costs and the absence of incentives to control costs are the most important factors contributing to the rapid escalation of Medicare expenditures. In 1983 approximately two-thirds of the increase in Medicare expenditures is attributable to cost inflation.

Since enactment of the Medicare and Medicaid program in 1965, total health care expenditures in the United States have increased at least 400 percent. The Federal share of that total has increased from $6 billion in 1965 to $70.9 billion in 1980. Costs of the Medicare program in 1981 were $42.5 billion, a 21.4 percent increase over 1980. In 1982 Medicare expenditures are projected to reach $49.8 billion, or a 17.2 percent increase over last year. Two-thirds of Medicare benefits are for inpatient hospital care; another fifth pays for physicians' services. In 1980, the Medicare Hospital Insurance trustees reported that even with scheduled increases in the Social Security payroll tax, which finances the fund, the Hospital Insurance trust fund would go broke shortly after 1990 unless measures are taken to reduce the rate of increase in program expenditures. The trustees also estimate that because of higher than originally estimated inflation in hospital costs, program outlays under current law may exceed income beginning in 1985. It is clear that both short term action to reduce Medicare expenditures and longer term structural changes in the health care system are needed to ensure that the Medicare system is maintained on a sound financial basis.

THE ADMINISTRATION'S GOALS

The success of President Reagan's economic recovery program is crucial in our fight against escalating health care costs. To put this in perspective, our actuaries tell me that each percentage point decrease in the rate of general inflation lowers the cost of the Medicare program by a half billion dollars.

As the Administrator of the Health Care Financing Administration, it is clear to me that the Medicare and Medicaid programs, with the support of the health care industry, have a leading role in the fight against inflation. In this regard, the Administration will submit to the Congress legislative proposals which will be aimed at encouraging greater competition in the health care sector through the promotion of consumer choice.

The fiscal year 1983 budget contains a series of proposals which would reform Medicare coverage policy and reimbursement to providers, while streamlining program administration. Major savings resulting from these proposals will be derived through provisions affecting reimbursement to hospitals and physicians, coordination with other insurance plans, and coverage of Federal employees under Part A. Our 1983 Medicare legislative and regulatory proposals, when implemented, will hold expenditures next year to $2.5 billion below what they otherwise would have been. Even with all the Medicare legislative and regulatory proposals included in our package, program expenditures in 1983 will be $6 billion more than our expected 1982 expenditures.

I would now like to briefly discuss with you some of the Medicare related proposals in which I understand the Subcommittee has expressed a particular interest:

Bring Federal employees under Medicare part A. This proposal would produce a revenue increase to the Federal budget of $619 million in 1983. For the first time, Federal workers would become eligible for Medicare based on their Federal employment.

Most workers in employment covered by Social Security are subject to the Hospital Insurance tax during their entire career. Federal employees, however, may earn the same coverage with relatively few years of work subject to the tax. We estimate that about 60 percent of Federal annuitants over age 65 currently qualify for Hospital Insurance benefits based on their own record in non-Federal employment or that of a spouse.

Modify Medicare coverage of the working aged. This proposal would result in net Federal savings of $303 million in 1983. Employers would be required to offer employees between ages 65 and 70 the same health benefits offered to younger workers. Employers who do not offer aged employees the same benefits as younger employees would not be permitted to claim the full cost of their health insurance as a tax deduction. Medicare would pay for services after the private insurer had covered its share of the total costs. As Medicare currently is the first payor, we have subsidized a substantial portion of the payroll costs of aged individuals enrollled in employer's health plans.

Medicare contractors. The budget request for the Administrative costs of Medicare carriers and intermediaries is at the same program level as in 1982 (i.e., $684 million or ongoing operating costs and a $20 million contingency to be used if unanticipated costs increases occur). The request reflects HCFA's continuing efforts to implement program efficiencies, including the application of new Automated Data Processing Technology. This new technology is already being used in the private sector for paper-less claims processing and the elimination of unnecessary contractor regulation, operating instructions and performance standards. We expect that these innovations will allow the program to accommodate increased workloads, with no increase in administrative costs.

We also propose to provide HCFA with additional administrative discretion regarding how intermediaries and carriers are chosen and the manner in which they are reimbursed. For example, we support elimination of the "nomination" process and request authority to use alternatives to the current cost-based reimbursement, such as competitive bidding and fixed-price or incentive arrangements, to produce the most economical results without sacrificing quality of services. Under the current non-competitive system, Medicare contractors have little or no incentive to perform their functions more efficiently. Thus, Federal costs are driven up by the system.

Reduce reimbursement to hospitals by 2 percent, Federal savings from this proposal would equal $653 million in 1983. The decrease of 2 percent in reimburseable hospital costs allowed by Medicare would be of an interim nature. We will continue to move forward on developing prospective reimbursement methodologies and with the competitive proposals I mentioned earlier. This approach is broadly similar to the Medicaid cost reductions adopted by the Congress in the Omnibus Budget Reconciliation Act of 1981 and has the same goal—reducing the rapid rate of increase in Federal health care expenditures.

Limit increase in the Medicare economic index to 5 percent. Total savings to the Medicare program from this proposal would amount to $35 million in 1983. We propose to limit the rate of increase that would occur through application of the Medicare economic index formula for 1983 to 5 percent (rather than an estimated 7.8 percent). Medicare physician reimbursement per enrollee has risen 17 percent in each of the last two years. This one-time limit would place a share of the burden of slowing the growth of health care expenditures, at a time of severe constraints on the Federal budget, on physicians.

Reimburse inpatient radiology and pathology service at 80 percent of reasonable charges. Proposed reforms in the way Medicare reimburses for these speciality services will result in savings of $160 million in 1983. The 1967 Social Security Amendments authorized Medicare to pay 100 percent of reasonable charges for inpatient services to radiologists and pathologists. This provision was intended to simplify reimbursement procedures and streamline claims processing through "combined billing" for the physicians's services and the hospital's services. Seventy-five percent of radiologists and pathologists do not submit combined bills. Furthermore, payment reviews are not possible with combined billing because procedures are not separately identified. We propose, therefore, to reimburse for these services in the same manner as all other physician services under Medicare. Such reimbursement levels will serve to assure that all physicians, regardless of specialty, are treated equitably under the Medicare program.

Eliminate duplicate Medicare payments for services in outpatient departments. This regulatory proposal will save $160 million in 1983. Physicians providing care in hospital outpatient departments are now paid the same rate by Medicare for services as they would be in their private offices. This is true even though the hospital is reimbursed in many cases separately for overhead costs. We propose, therefore, to refine the application of the Medicare "customary and prevailing charge" screens to reflect more accurately allowable charges for professional services provided in different locations.

I would like now to discuss very briefly a few others of the over 50 major and technical proposals included in our budget. All are designed to make Medicare a more cost-efficient program:

Professional standards review organizations (PSRO). As part of the Administration's commitment to reduce the regulatory burden on the private sector, we are again proposing legislation to eliminate the requirement for PSRO review of Medicare services. We anticipate that those PSROs with demonstrated effectiveness will be able to continue operations by marketing their services in both the private and public sector.

Begin Medicare coverage on the first day of the month following the month in which age 65 is achieved. Medicare coverage for both Hospital and Supplemental Medical insurance would begin with the first day of the month following the month of an individual's 65th birthday rather than the first day of that month. Enactment of this proposal would produce savings of $145 million in 1983.

Index Part B deductible to Consumer Price Index. We propose to index the Part B deductible to the consumer price index beginning in 1983. Our proposal is similar to one included in the House version of last year's Reconciliation Bill. Despite a 250 percent increase between 1972–1981 in program expenditures per aged enrollee, there was no increase in the deductible amount until this Congress decided last year to raise it from $60 to $75. Had the deductible kept pace with inflation, it would have been well over $100. Rapid increases in health care costs, as well as inflation, negate the impact of a static deductible in deterring unnecessary utilization of services. Social Security cash benefits are indexed to account for increases in the cost of living. In addition, the part A deductible and coinsurances and the part B premium are adjusted to reflect increases in program costs. In like fashion, indexing of the deductible would keep its value constant. This would produce savings of $65 million in 1983.

Require minimal copayments on home health services under Medicare. Our proposal would require 5 percent coinsurance for all home health visits. Such a small increase in cost-sharing is reasonable and should not deter the use of necessary home health services. However, coinsurance should deter unnecessary utilization: a recent General Accounting Office (GAO) audit found that 27 percent of home health visits covered by Medicare were of questionable necessity. Savings from enactment of this proposal would be $35 million in 1983.

Update part B physician fee screen on October 1. This legislative proposal would extend the current fee screen year (July 1, 1981—June 30, 1982) to September 30, 1982, and establish all future fee screen years on a new fiscal year basis. Enactment of this proposal would result in savings of $210 million in 1983.

Eliminate waiver of provider liability. Institutional providers which furnish noncovered care to a Medicare beneficiary would no longer be free of liability for costs of that care. It is imprudent for the Federal government to pay for services found to be uncovered or unnecessary simply because the providers were not aware of Medicare coverage rules.

We believe making providers liable will give them an incentive to make themselves aware of those rules and better manage admission and treatment policies. Our proposal would continue to protect from liability beneficiaries who were not aware that the services were not covered.

In conclusion, I would like to reiterate that we must control increasing costs of the Medicare program. I believe enactment of our 1983 proposals is essential to insuring that Medicare continues to meet the basic health care needs of our elderly and disabled population.

Mr. Chairman, this concludes my statement. My associates and I would be happy to answer any questions the members of the Subcommittee may have.

Chairman JACOBS. Thank you very much, Dr. Davis.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Dr. Davis, I regret I was not here at the beginning of your presentation, although I have heard most of the testimony that you have presented. I want to thank you for the presentation which you have made and for the wide range of ideas that you are presenting for consideration by this committee. No doubt there will be some that we agree with and some that we disagree with before the process is finished, but you have certainly put the discussion on a proper level looking into all manner of considerations which we should take into account.

I particularly want to compliment you for the emphasis which you placed on the importance of a gradual shift to a prospective rather than retrospective accounting system. This is something that we have been talking about here in this committee, and I know a lot of people in the provider fields have been talking about for a long while. And I for one want to not only compliment you but encourage you to move that ahead just as quickly as it can be done.

It certainly seems to be a fundamental structural change that along with some of the other ideas which you discussed may in the long run help to contain costs and still maintain a high quality of medical care.

Thank you, Mr. Chairman.

Chairman JACOBS. Thank you, Mr. Gradison.

Mr. Anthony.

Mr. ANTHONY. One area that I would like to talk to you about, Mrs. Davis, would be the 2-percent, across-the-board cut. What, in your opinion, will be the effect on the hospitals? My hometown is El Dorado, Ark. We have two hospitals. One is charitable. One is operated by the county. Let's take the county, for instance. If they have a 2-percent cut across the board, what do you think in all likelihood the administrator of that hospital will decide to do as far as shifting the allocation of costs to offset what the Federal Government does?

Ms. DAVIS. Mr. Anthony, I would certainly hope that the administrators of hospitals would exercise more prudent management. I believe that last year's inflationary rate of 19 percent for hospital costs is simply unacceptable.

Even with the 2-percent reduction, we estimate that hospitals will still have a 13-percent increase in their costs for next fiscal year. I believe it would be prudent to expect that they could live within that without a cost-shifting arrangement.

Having been a health care provider myself, having worked within a hospital system, as well as having been on the board of trustees of a hospital, I can assure you that there are still inefficiencies in the systems. And we believe that the 2-percent reduction would simply allow for more incentives for the hospitals to become more efficient.

Mr. ANTHONY. All right. Well, let's take it one step further. Let's assume that they do not operate efficiently. Let's assume that they do not have as good management practices as you would hope they would. And let's now look at what I may consider a more reasonable or more pessimistic point.

Assuming that they do not find a 2-percent-management-initiative savings, what does your study tell you is likely to happen? As you thought through this, and before you decided to put this down as one of your proposals, what was one of the, if you want to call it adverse, or what was one of the conclusions that you reached that possibly could happen—a likelihood that the costs would be shifted to another patient?

Ms. DAVIS. No. Again, I would refer to the fact that we believe that there are enough inefficiencies within the system, and with that dreadful inflation rate, we believe that they really would concentrate on reducing the inefficiencies. I do not believe there is a hospital around that has yet achieved enough efficiency within their systems.

Let me also point out, Mr. Anthony, that we view this as an interim measure.

Mr. ANTHONY. I am sorry. I did not hear you.

Ms. DAVIS. It is an interim measure. It is a simple, direct, easily administered and easily accomplished interim solution to slow the growth in hospital costs while we work on our prospective reimbursement system.

I am a firm believer that much of the problem within the system has been created because of the retrospective cost-based system. With the retrospective cost system there is no incentive for efficient management within hospitals. That is why even as we speak, our task force on prospective payment systems is meeting and is working out the final details on a number of the methodologies that they are going to propose.

Mr. ANTHONY. I applaud you in those efforts. I support you in those efforts also.

Could you give us a timetable as to when that task force may come forward with a recommendation?

Ms. DAVIS. Yes; I anticipate that the final work of the task force will conclude at the end of March. I expect to be meeting with them for a couple of hours this afternoon. We have some interim reports that we will be working on, but I think it will be the end of March before I move the recommendation forward to the Secretary.

Mr. ANTHONY. Let me state my concern a little bit more clearly for the record, and then ask you a final question. If after hearing testimony, and if after I individually and other Members of Congress individually talk to their hospital administrators and come to an honest opinion that those management initiative savings cannot be found, and that in more likelihood there is going to be a cost shift to the private patient, if we can clearly demonstrate that for the record, is your position so inflexible that you would not be willing to take a new look at it? Or if we can demonstrate that for the record, are you willing to take a new look at that particular proposal?

Ms. DAVIS. We considered a number of alternatives, Mr. Anthony, before we arrived at our position on the 2 percent; and we believe that the 2-percent proposal is the simplest and the most effective way for us to achieve this savings for this particular year.

Mr. ANTHONY. All right. So what you are saying then, is even if we demonstrate clearly to the record, to a great majority of people on this committee or in the Congress, you are just going to continue to disagree with us and say you are not willing to work with us to make any suggested alternatives.

Is that what you are telling me? I mean it appears to me that you have your feet locked in, and that what you are proposing is that you just are not willing—I do not want to be argumentative with you about it, but I am trying to state it in such a way that only after the record would be clearly demonstrated, because I do not have any preconceived idea right now whether it is good or bad. I am just telling you that these other views that are coming to me in forms of letters, personal visits with these administrators, cause me some concern.

Ms. DAVIS. Mr. Anthony, we are always willing to enter into conversations with Members of Congress if their findings are different than ours. However, I would like to emphasize that we believe that some costs simply should not be paid by anyone and that there should not be cost shifting going on in the system. So I would urge very detailed consideration of what is being sent forward.

Mr. ANTHONY. I understand we all have a difficult task to slow down the health costs, and we are going to be here trying to work with you and help you do that.

Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

Dr. Davis, you are planning to reduce, I think through regulation, the amount medicare will pay for physician services and hospital outpatient departments. Will this reduction also apply in the case of emergency departments?

Ms. DAVIS. Our proposal includes all covered outpatient services, and we would view emergency room coverage as part of the outpatient services.

Mr. DUNCAN. And then you are proposing to update the physicians' fee screens each October rather than in July. Right now the July update is based on charges made by doctors during the previous calendar year. And when you postpone the fee update by as much as 3 months, will you retain the calendar year provision?

Ms. DAVIS. Yes, we will.

Mr. DUNCAN. So if you do that, then the lag in recognizing fee increases will grow by 3 months. And I am sure you are aware of the fact that there are already many complaints about how out of date medicare allowable charges are.

Mr. SCHIEBER. We feel that to a large extent the system is known by physicians, and by and large physicians have built these lags into their fees, which are really based on their billings.

I think the other point, Mr. Duncan, that is really the crucial issue, is, are medicare physician payment levels relative to other payers? As one would expect, that is somewhat variable, but in many places in the country we are actually paying more than the private plans.

Mr. DUNCAN. But the charges are passed right on to the patients.

Mr. SCHIEBER. Not on assigned claims.

Mr. DUNCAN. But if the lag time is 9 months, will not this reduce the time—reduce the number that will take assignments?

Mr. SCHIEBER. I think when you——

Mr. DUNCAN. To reduce——

Mr. SCHIEBER. It is possible that could happen, clearly.

Mr. DUNCAN. It could happen if you increased the lag time that much. You lost some because of the 6-months' lag time. Now you have 9 months.

Mr. SCHIEBER. Well, the assignment rate has been relatively stable for the last 8 years. I think the real issue is exactly how a physician is going to react to this. Some physicians may well reduce their assignments or not take assignments.

I think the issue is that despite all the physician changes we are talking about—and there are four proposals here which impact on physicians—what we are essentially doing is reducing what would have been an 18-percent increase in physician payments under medicare to a 13-percent increase.

And I think the other point I would make, sir, is that what we are really talking about here is a reduction in the rate of increase. We are not talking about reducing fees. All these items taken together just factor into a small reduction in the rate of increase, and we would hope it would not have a very major effect on the assignment rate.

Ms. DAVIS. Mr. Duncan, we are also talking about a group of individuals who have an average income of approximately $81,000 a year.

Mr. DUNCAN. Who is going to pay the difference on the 18 to 13, the 13 to 18, the doctor or the patient?

Ms. DAVIS. We would certainly hope that the physicians, whose average income is about $81,000, would simply delay an update in terms of asking beneficiaries to pay more. I think they will join us in the fight against inflation.

Mr. DUNCAN. You think the doctor will pay instead of the patient, is that correct?

Ms. DAVIS. I think they will delay raising their fees, and I believe that with a net income level that averages $81,000 and ranges from some $63,000 to $98,000, they can better afford that than the beneficiary can.

Mr. DUNCAN. The $81,000, is that nationwide?

Ms. DAVIS. That is an average that was given to us for the 1980——

Mr. DUNCAN. What is it in Tennessee?

Ms. DAVIS. I would have to submit that to you for the record.

[See attached charts:]

Center for Health Services Research and Development
AMERICAN MEDICAL ASSOCIATION

Profile of Medical Practice 1981

David L. Goldfarb
Editor

Physicians' Net Incomes

For the average physician, net income from medical practice rose by an average annual rate of 7.2% from 1970 to 1979. The annual percentage increases in average net income from 1970 to 1979 were, by specialty:

Specialty	1970-1979
• Anesthesiology	9.8
• Obstetrics/Gynecology	7.7
• Surgery	7.4
• Internal Medicine	7.3
• General Practice	6.9
• Pediatrics	6.3
• Psychiatry	5.1

Net income from medical practice shows a consistent pattern by census division in 1979. Physicians in the East South Central census division had the highest mean net income for 1979 ($87,000). Further, physicians in the New England census division had the lowest mean net income for 1979 ($66,600). Other features of net income in 1979 include the following:

- The highest 1979 average net income occurred for physicians in metropolitan areas of one million or more persons ($78,800) followed by physicians in metropolitan areas of less than one million persons ($78,700) and physicians in nonmetropolitan areas ($76,400).
- Physicans age 41 through 45 earned the highest average net income in 1979 ($91,300) while physicians age 61 and over earned the least net income in 1979 ($63,200).

Slightly over one-half of physicians reported that their medical practice was a corporation in 1980. This percentage varied from a high of 72% for anesthesiologists to a low of 33% for psychiatrists. Further, the average 1979 net income for incorporated physicians ($92,000) exceeded that for physicians who are not incorporated ($64,500).

Table 40—Average Net Income from Medical Practice by Specialty, 1970-1979

Specialty	Year									
	1970	1971	1972	1973	1974	1975	1976[c]	1977	1978	1979
Total[b]	$41,800	$45,300	$47,200	$48,600	$52,000	$56,400	$59,500	$61,200	$65,500	$78,400
General Practice	33,900	39,800	41,300	41,900	44,700	45,400	47,400	51,200	54,600	62,000
Internal Medicine	40,300	42,900	44,700	47,800	51,400	57,000	60,500	61,500	63,800	76,200
Surgery	50,700	54,000	56,000	57,200	60,500	68,200	73,200	74,000	82,600	96,000
Pediatrics	34,800	38,500	38,900	41,200	42,100	44,300	47,000	48,200	51,200	60,400
Ob./Gynecology	47,100	51,100	53,200	55,400	61,700	63,300	65,800	69,900	70,300	91,800
Psychiatry	39,900	37,200	39,100	38,500	41,300	44,800	47,600	48,200	50,200	62,600
Anesthesiology	39,400	47,300	49,500	48,100	54,400	57,100	60,100	65,500	74,200	91,400

[a] Because of differences in sampling procedure, figures may not be consistent with previously published data for some years. [b] Physicians whose specialties were classified as Radiology and "Other" are included in this total. [c] Projected by respondents.

Source: Periodic Survey of Physicians, 1970-1980. Center for Health Services Research and Development, American Medical Association.

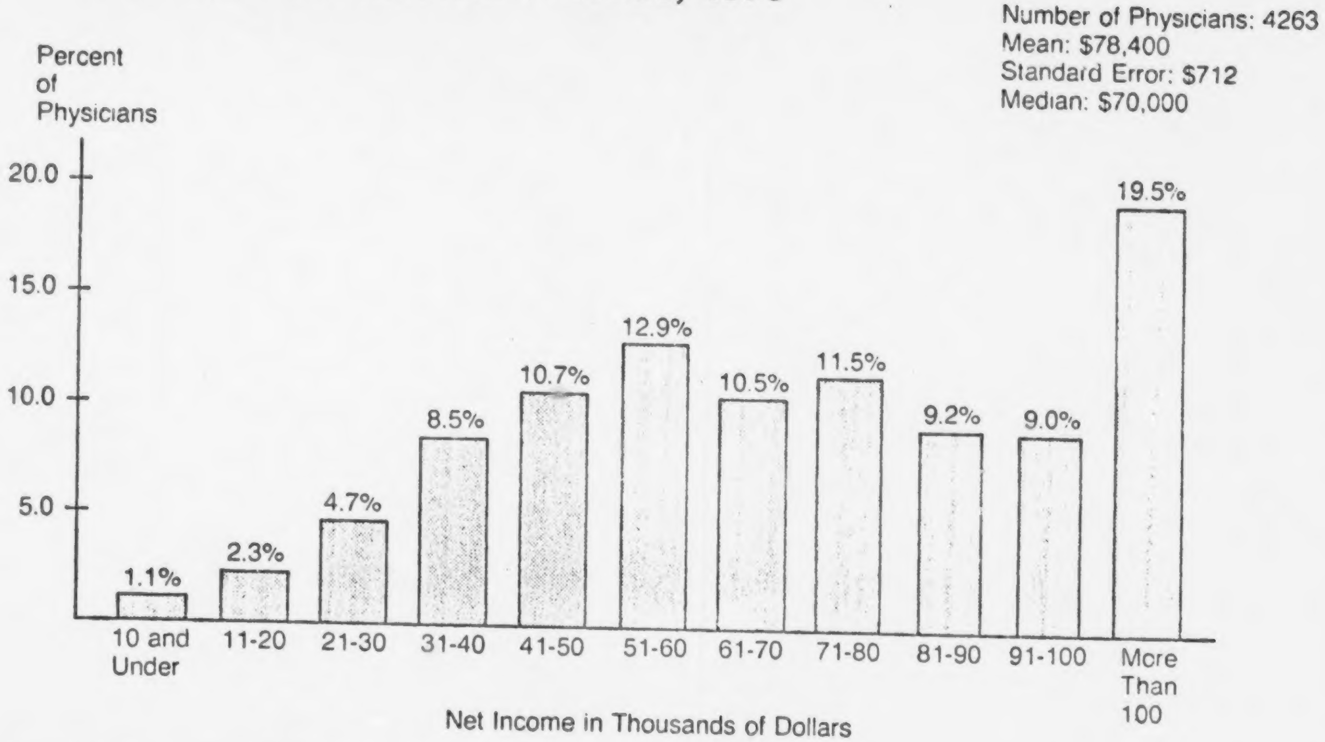
Table 41—Average Net Income from Medical Practice by Census Division and Specialty, 1979

Census Division	Total		Specialty							
	N	Mean	Gen.Prac. (N=818)	Int.Med. (N=763)	Surg. (N=949)	Ped. (N=278)	Ob./Gyn. (N=318)	Rad. (N=181)	Psych. (N=334)	Anes. (N=188)
			Mean							
Total[a]	4,263	$78,400	$62,000	$76,200	$96,000	$60,400	$91,800	$98,000	$62,600	$91,400
New England	253	66,600	46,300	64,200	78,100	57,900	75,700	78,700	57,100	b
Mid Atlantic	763	73,200	50,200	69,100	94,400	49,900	93,200	107,300	61,200	82,400
E. N. Central	699	81,200	62,200	82,000	95,900	66,400	97,800	103,800	71,100	96,500
W. N. Central	296	79,400	67,300	74,400	98,600	62,900	97,300	102,300	69,000	96,700
South Atlantic	661	79,800	66,900	81,500	96,400	57,400	87,100	100,400	57,000	90,300
E. S. Central	203	87,000	77,100	79,600	106,000	71,800	91,500	100,800	55,300	79,500
W. S. Central	362	85,800	71,800	86,600	99,500	71,300	89,600	104,900	98,800	118,700
Mountain	202	73,500	62,800	62,600	86,100	51,800	95,100	78,300	67,500	62,000
Pacific	824	78,600	56,600	78,300	101,200	64,100	94,700	81,600	54,600	103,700
		Standard Error of the Mean								
Total		712	1,301	1,574	1,671	1,538	2,866	5,393	2,014	2,616
New England		2,108	3,450	4,232	5,122	6,466	7,675	6,640	4,261	b
Mid Atlantic		1,834	2,299	2,832	3,956	2,414	6,565	27,171	2,940	4,695
E. N. Central		1,696	2,522	4,159	4,073	4,415	8,592	7,459	4,544	6,068
W. N. Central		2,115	3,202	5,999	5,316	8,465	13,426	7,124	5,533	7,525
South Atlantic		1,674	3,177	3,978	4,101	3,161	5,083	9,401	3,301	7,385
E. S. Central		4,013	14,194	5,756	7,261	7,297	18,625	10,856	13,348	5,817
W. S. Central		2,751	3,896	5,846	8,194	5,592	8,201	11,308	28,507	11,004
Mountain		2,469	5,559	6,544	4,398	6,774	8,463	7,240	8,255	3,620
Pacific		1,702	2,889	4,226	4,335	3,592	7,419	7,950	3,163	6,935

[a] Total includes "Other" category. [b] Data do not meet reliability standards.

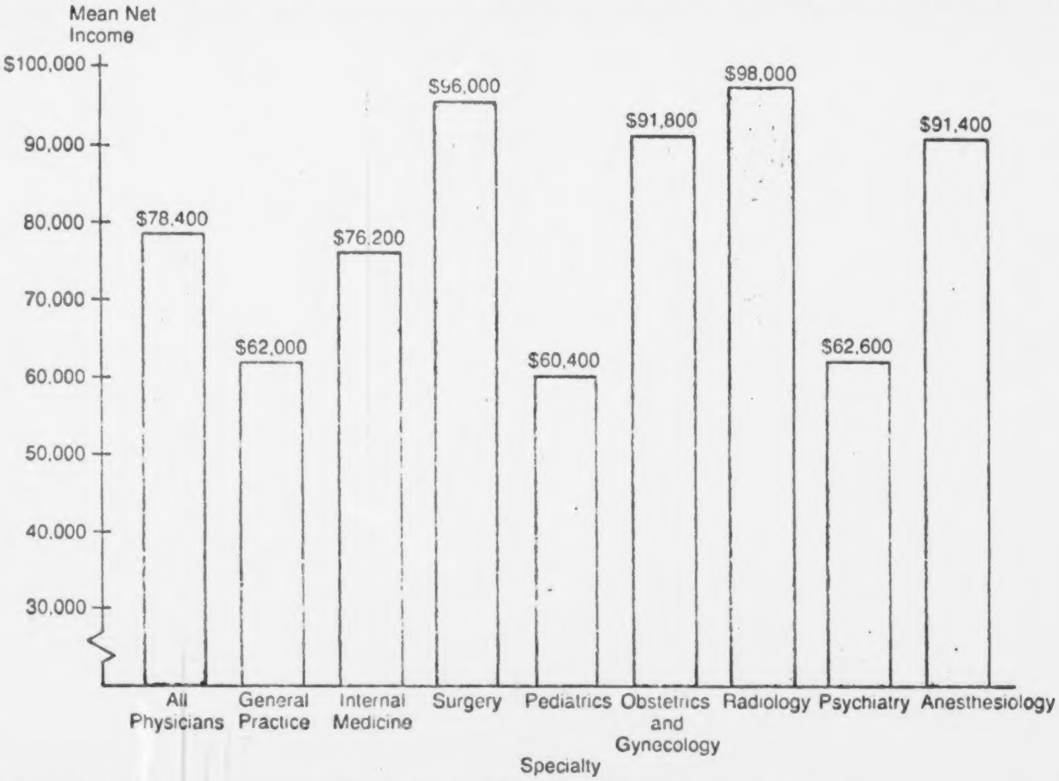
Source: Fourteenth Periodic Survey of Physicians. March 1980. Center for Health Services Research and Development, American Medical Association.

Figure 3—Percentage Distribution of Physicians by Net Income from Medical Practice, 1979



Source: Fourteenth Periodic Survey of Physicians March 1980. Center for Health Services Research and Development, American Medical Association.

Figure 4—Mean Net Income from Medical Practice by Specialty, 1979



Source: Fourteenth Periodic Survey of Physicians, March 1980. Center for Health Services Research and Development, American Medical Association.

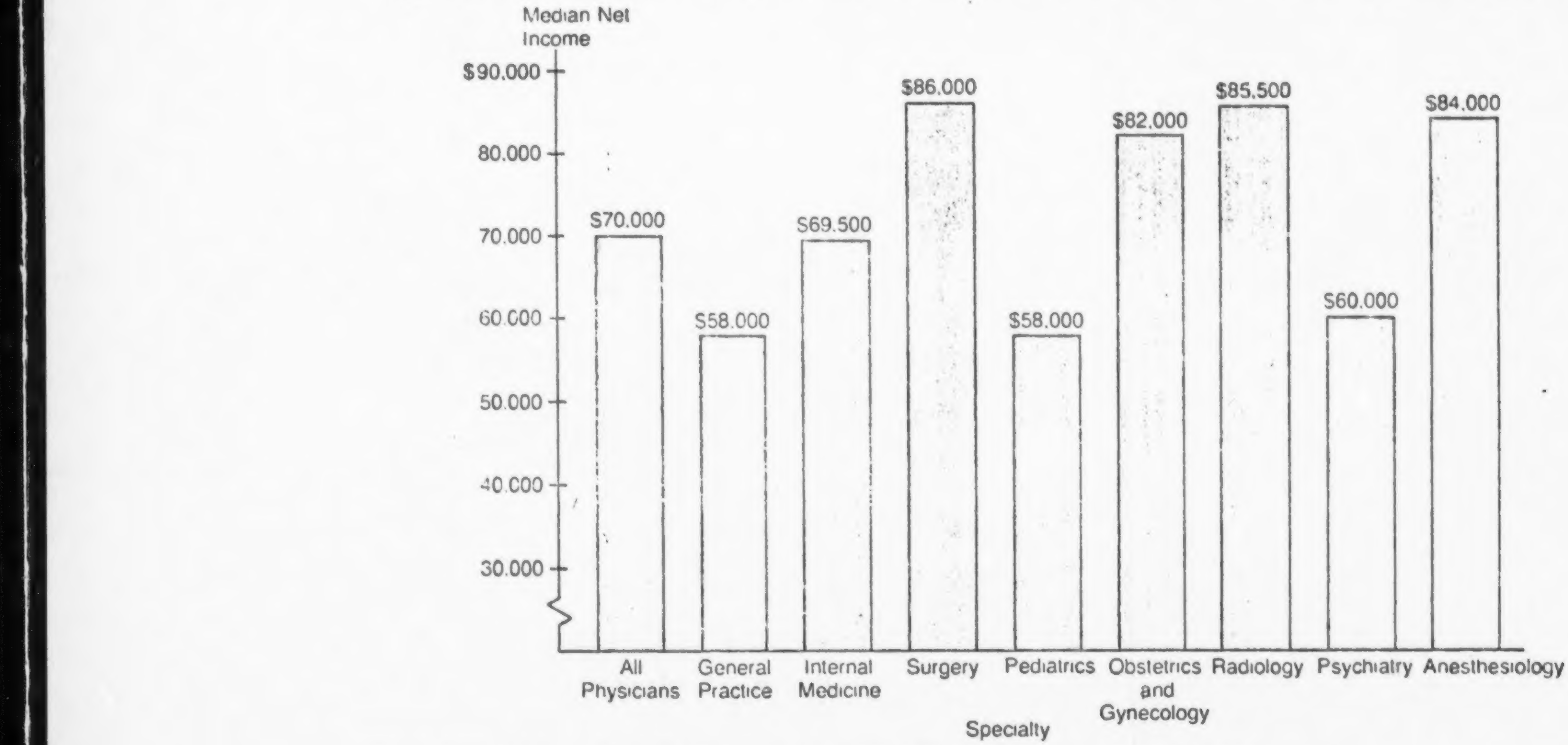
Table 42—Median Net Income from Medical Practice by Census Division and Specialty, 1979

Census Division	Total		Specialty							
	N	Median	Gen.Prac. (N=818)	Int.Med. (N=763)	Surg. (N=949)	Ped. (N=278)	Ob./Gyn. (N=318)	Rad. (N=181)	Psych. (N=334)	Anes. (N=188)
			Median							
Total[a]	4,263	$70,000	$58,000	$69,500	$86,000	$58,000	$82,000	$85,500	60,000	84,000
New England	253	60,000	40,500	54,000	70,000	62,500	65,000	80,000	55,000	b
Mid Atlantic	763	62,000	48,000	60,000	85,000	48,000	83,000	75,500	60,000	80,000
E. N. Central	699	75,000	60,000	75,000	84,000	60,000	80,000	95,500	69,000	95,000
W. N. Central	296	72,000	60,000	67,000	96,000	56,500	98,000	97,000	64,500	96,000
South Atlantic	661	73,000	60,000	74,000	87,000	54,500	80,000	86,500	57,500	80,000
E. S. Central	203	80,000	63,000	78,000	100,000	72,000	70,000	104,000	45,500	80,000
W. S. Central	362	75,000	66,000	78,000	85,000	65,000	85,000	87,000	69,000	110,500
Mountain	202	70,000	56,500	60,000	82,000	41,000	86,500	70,000	62,000	60,000
Pacific	824	70,000	52,000	70,000	90,000	60,000	84,000	72,000	50,000	100,000

[a] Total includes "Other" category. [b] Data do not meet reliability standards.

Source: Fourteenth Periodic Survey of Physicians. March 1980. Center for Health Services Research and Development, American Medical Association.

Figure 5—Median Net Income from Medical Practice by Specialty, 1979



Source Fourteenth Periodic Survey of Physicians. March 1980. Center for Health Services Research and Development. American Medical Association.

Table 43—Average Net Income from Medical Practice by Specialty and Location, 1979

			Location		
			Nonmetropolitan	Metropolitan	
	Total			Less than 1,000,000[b]	1,000,000 and over[c]
Specialty	N	Mean	(N=662)	(N=1447)	(N=2154)
				Mean	
Total[a]	4,263	$78,400	$76,400	$78,700	$78,800
General Practice	818	62,000	69,200	59,600	57,700
Internal Medicine	763	76,200	75,800	75,800	76,500
Surgery	949	96,000	91,400	96,200	97,300
Pediatrics	278	60,400	59,200	69,900	60,200
Obstetrics/Gynecology	318	91,800	94,800	91,400	91,400
Radiology	181	98,000	94,100	100,000	97,700
Psychiatry	334	62,600	58,400	60,300	63,900
Anesthesiology	188	91,400	70,700	93,400	93,200
				Standard Error of the Mean	
Total		712	1,773	1,148	1,047
General Practice		1,301	2,902	1,827	1,884
Internal Medicine		1,574	4,241	3,078	1,988
Surgery		1,671	3,643	2,693	2,563
Pediatrics		1,538	4,217	2,742	2,053
Obstetrics/Gynecology		2,866	10,682	4,239	3,964
Radiology		5,393	8,256	4,917	10,099
Psychiatry		2,014	5,164	2,866	2,746
Anesthesiology		2,616	6,714	4,489	3,495

[a] Total includes "Other" category. [b] All counties in SMSAs with 50,000 to 999,999 inhabitants and all counties considered potential SMSAs. [c] All counties in SMSAs with 1,000,000 or more inhabitants.

Source: Fourteenth Periodic Survey of Physicians. March 1980. Center for Health Services Research and Development, American Medical Association.

Table 44—Median Net Income from Medical Practice by Specialty and Location, 1979

			Location		
			Nonmetropolitan	Metropolitan	
	Total			Less than 1,000,000[b]	1,000,000 and over[c]
Specialty	N	Median	(N=662)	(N=1147)	(N=2154)
			Median		
Total[a]	4,263	$70,000	$68,000	$72,000	$70,000
General Practice	818	58,000	60,000	54,000	55,000
Internal Medicine	763	69,500	65,500	68,500	70,000
Surgery	949	86,000	85,000	90,000	85,000
Pediatrics	278	58,000	54,000	55,000	60,000
Obstetrics/Gynecology	318	82,000	80,000	86,000	80,000
Radiology	181	85,500	90,000	96,000	80,000
Psychiatry	334	60,000	50,000	55,500	60,000
Anesthesiology	188	84,000	62,000	85,000	85,000

[a] Total includes "Other" category. [b] Includes all counties in SMSAs with 50,000 to 999,999 inhabitants and all counties considered potential SMSAs. [c] Includes all counties in SMSAs with 1,000,000 or more inhabitants

Source: Fourteenth Periodic Survey of Physicians. March 1980. Center for Health Services Research and Development, American Medical Association.

Table 45—Average Net Income from Medical Practice by Specialty and Corporation Status, 1979

Specialty	Total N	Total Mean	Status: Not Incorporated (N=2086)	Status: Incorporated (N=2153)
			Mean	
Total[a]	4,263	$78,400	$64,500	$ 92,000
General Practice	818	62,000	57,000	71,900
Internal Medicine	763	76,200	63,400	90,000
Surgery	949	96,000	77,100	106,400
Pediatrics	278	60,400	57,500	65,100
Obstetrics/Gynecology	318	91,800	75,400	99,900
Radiology	181	98,000	92,000	101,200
Psychiatry	334	62,600	57,600	73,000
Anesthesiology	188	91,400	76,400	96,800
		Standard Error of the Mean		
Total		715	891	1,032
General Practice		1,308	1,660	2,158
Internal Medicine		1,584	1,663	2,565
Surgery		1,675	2,416	2,117
Pediatrics		1,544	1,970	2,430
Obstetrics/Gynecology		2,866	4,055	3,641
Radiology		5,393	14,085	3,500
Psychiatry		2,023	1,857	4,687
Anesthesiology		2,616	3,444	3,223

[a] Total includes "Other" category.

Source: Fourteenth Periodic Survey of Physicians. March 1980. Center for Health Services Research and Development, American Medical Association.

Table 46—Median Net Income from Medical Practice by Specialty and Corporation Status, 1979

Specialty	Total		Status	
			Not Incorporated	Incorporated
	N	Median	(N=2086)	(N=2153)
			Median	
Total[a]	4,263	$70,000	$60,000	$82,000
Gen. Practice	818	58,000	50,000	65,000
Int. Medicine	763	69,500	60,000	80,000
Surgery	949	86,000	70,000	99,000
Pediatrics	278	58,000	55,000	62,000
Obstetrics/Gynecology	318	82,000	70,000	90,000
Radiology	181	85,500	70,000	97,000
Psychiatry	334	60,000	54,000	67,000
Anesthesiology	188	84,000	75,000	90,000

[a] Total includes "Other" category.

Source: Fourteenth Periodic Survey of Physicians. March 1980. Center for Health Services Research and Development, American Medical Association.

Table 47—Percentage of Physicians Who Are Incorporated by Census Division and Specialty, 1980

Census Division	Total		Specialty							
			Gen. Prac. (N=978)	Int. Med. (N=918)	Surg. (N=1143)	Ped. (N=330)	Ob./ Gyn. (N=381)	Rad. (N=216)	Psych. (N=378)	Anes. (N=214)
	N	Percent	Percent							
Total[a]	5,050	51%	35%	49%	65%	40%	67%	67%	33%	72%
New England	302	39	b	29	53	44	71	77	16	50
Mid Atlantic	920	42	20	39	60	37	72	50	27	57
E. N. Central	829	57	36	60	66	47	73	78	42	92
W. N. Central	340	54	45	65	68	19	73	65	52	73
South Atlantic	779	55	42	56	65	41	59	80	36	78
E. S. Central	251	53	29	67	62	58	58	75	b	50
W. S. Central	426	53	43	41	68	50	69	61	45	64
Mountain	232	53	38	51	67	42	47	63	b	64
Pacific	971	52	35	45	72	34	66	63	34	83

[a] Total includes "Other" category. [b] Data do not meet reliability standards.

Source: Fourteenth Periodic Survey of Physicians. March 1980. Center for Health Services Research and Development, American Medical Association.

Mr. DUNCAN. Do you have that State by State and also do you have a breakdown of hospital by hospital of exactly how much the 2-percent reduction in medicare would affect the hospital?

Ms. DAVIS. We do not have a breakdown by hospital on the 2 percent. Again, I will try to get the information on physicians by State.

Mr. DUNCAN. Do you plan to get that information?

Mr. SCHIEBER. We will try to get it for you. I believe that the data we are using is the American Medical Association's economic data, and I believe it is by region. I do not believe they have it by State, but we will check that, and if we can get it, sir, we will get it to you for the record.

Mr. DUNCAN. Mr. Chairman, I would like unanimous consent that I may submit questions in writing.

Chairman JACOBS. Without objection, so ordered.

[No questions were submitted.]

Mr. DUNCAN. I yield back the balance of my time.

Chairman JACOBS. Mr. Holland.

Mr. HOLLAND. Thank you, Mr. Chairman.

Dr. Davis, the administration in its budget has something that I have dubbed PSAMIURI. The letters are P-S-A-M-I-U-R-I—[private sector and medicare intermediary utilization review initative] PSAMIURI. [Laughter.]

You say you are going to save $330 million with PSAMIURI, and I am interested in knowing as we pass review on this budget exactly where these savings estimates come from. How did you derive this number?

Ms. DAVIS. We derived them from two factors, Mr. Holland. One was that we intended to ask the medicare contractors to engage in utilization review. We are working with our medicare contractors in several task forces now in order to streamline their operations. We expect to have more computerized claims processing activities. And as we then release some of the funds that would have been used under this year's normal type of operations in terms of streamlining the operations, we will then have more funds to use for the utilization review effort from the contractors.

We think that that is a prudent way to go because contractors are already reviewing the billing forms themselves. They will focus on some audits and streamlining operations. We anticipate that they will focus review. They will be given savings targets and will have the flexibility to work within an overall program, but they can focus on their own local patterns of aberrant behavior in order to achieve that from the public sector.

We also recognize that there is a significant effort in the private sector through both the voluntary effort and the coalition's activities; and we anticipate that those two will be working on reduction of utilization in hospitals, and that is one of the largest areas that we recognize adds to our costs right now.

Mr. HOLLAND. I am not sure I followed you there, but we will move along here to something else. You propose to impose on Federal employees the medicare part of social security. I am wondering what is going to happen to those Federal employees who are nearing retirement and who have not paid in and will not have the opportunity prior to retirement. It requires 40 quarters.

What sort of transitional rules do you plan?

Ms. DAVIS. Mr. Holland, we have considered that, and we would be phasing those people in. We are working on a grandfathering situation where they would be phased in to the system with less required quarters. The Office of Personnel Management [OPM] is working on that at this time.

Mr. HOLLAND. Let me go back to PSAMIURI a minute. Do you anticipate that a large part of the savings would be from medicare intermediaries retroactively denying payment to hospitals after they have submitted their bills?

Ms. DAVIS. No. I really believe that a number of these audits in terms of focusing will lead to more efficient review. I think that in conjunction with the efforts from the private sector's voluntary effort which encompasses hospitals and physicians, we will achieve those savings.

Mr. HOLLAND. The President's budget includes a proposal to reduce hospital cost reimbursement by 2 percent. Do you not anticipate that the providers will shift that 2 percent to the patients?

Ms. DAVIS. Mr. Holland, as I stated earlier, we believe that the 19-percent growth rate in hospital costs that occurred last year is simply unacceptable. We think that does show significant inefficiencies in the system and we would expect that hospitals would become more efficient. Hospitals will still get a significant increase over last year.

We will also prohibit the hospitals from moving their costs over to medicare beneficiaries.

Mr. HOLLAND. I will yield to the gentleman in just a moment. I want to get this question asked at least before I stop.

Do you not have some suspicion that the costs at least are going to continue to skyrocket and that whatever the Government does not pay for the elderly and people who are entitled to coverage under various Government programs, do you not really—or have you not thought that possibly some of these bighearted hospitals and providers are going to just shift that Federal money loss over to the private patient, who can in most cases not afford even what they have to pay now?

Has that not occurred to you, Dr. Davis? Are you a medical doctor or a Ph. D.?

Ms. DAVIS. I have a Ph. D. and I am a nurse.

Ms. FEINSTEIN. Mr. Holland, our challenge is to bring the rate of growth down, not to reduce reimbursement. Our preferred position with respect to hospital reimbursement is moving in the direction of prospective payment, where the provider will know in advance what he is being reimbursed for in providing a given unit of service.

In the interim, though, we have a tremendous cost escalation problem and we believe the 2-percent solution is the right way to go.

Mr. HOLLAND. Have you thought that possibly hospital cost containment legislation may operate just as well?

Ms. FEINSTEIN. I think our proposed solution is the best alternative, instead of putting into place a number of regulatory provisions which would require significant audit, significant utilization of cost data, again on a retrospective basis, which is not the proper way to go. We want to move toward prospective payment and move away from cost data and auditing.

Mr. **Holland**. I now yield to my friend from Arkansas.

Mr. **Anthony**. I thank the gentleman for yielding.

I would like to follow up on a point that Mr. Holland was making about the cost and the shifting of the cost. You made a statement on page 3 that your actuary study shows that each percentage point decrease in the rate of general inflation lowers the cost of the medicare program by half a billion dollars.

I know the administration has been taking strong credit for bringing inflation down below double-digit figures, down to—what figure are you currently using in your budget?

Ms. **Davis**. We estimate 14.8 percent on the part A side and 15.8 on the part B, for a total of 15.

Mr. **Anthony**. Would you repeat that—15-what part?

Ms. **Davis**. I beg your pardon?

Mr. **Anthony**. What was the percent of inflation on part A?

Ms. **Davis**. It is a combination of both the inflation and the increases in utilization. Our estimate is 14.8 percent in part A and 15.8 in part B outlays, for a combined total of 15 percent.

Mr. **Anthony**. So actually when——

Ms. **Davis**. Mr. Anthony, these are our projections after all of our legislative and regulatory proposals have been implemented.

Mr. **Anthony**. Oh, I see, that is a projection afterwards.

Ms. **Davis**. Excuse me. That is the inflation rate before we begin.

Mr. **Anthony**. That is the inflation rate that you are using before the initiatives?

Ms. **Davis**. Yes.

Mr. **Anthony**. What would you then anticipate the inflation rate would be after all your initiatives were passed?

Mr. **Schieber**. Without any of our proposals, medicare spending will increase about 15 percent. With the proposals it would still increase about 12 percent.

Mr. **Anthony**. Where is the difference, then, between the 15 and the figure that you used a while ago, 18½ or 19-percent growth in health care costs last year? Where are those 3 missing inflation points?

Ms. **Davis**. The 18 percent was the growth in hospital costs.

Mr. **Anthony**. Hospital costs.

Ms. **Davis**. Yes, this is a general rate of growth in all the health care expenditures. This includes hospitals, physicians, home health, the whole gamut.

Mr. **Anthony**. All right. So when you then talk about lowering the inflation rate from double digit figures down to 7.5, we have got to set that aside for the health care area and we have to look at some different figures. Is that what you are telling me?

Mr. **Sexton**. That is correct.

Ms. **Davis**. That is correct.

Mr. **Anthony**. So basically then you are telling me there have been no savings, and in fact there has been a continual drain as far as inflation is concerned on the health care costs on page 3. In other words, you are saying that your actuaries are telling you that it is costing medicare more because of inflation, rather than saving money by lowering inflation at the present time.

Mr. SEXTON. No, I think the fiscal year 1982 numbers, even without the change from 1983 over 1982, is smaller than the increase in 1982 over 1981, even before you begin to take into effect these additional legislative and regulatory proposals. So there has been a decrease. It is not nearly as much of a decrease as in the overall rate of inflation. But there are a couple of percentage points decrease from 1983 over 1982 even before you begin the legislative proposals.

Mr. ANTHONY. I thank the gentleman for yielding.

Mr. Chairman, I do not want to take any more time, but this is an area I would like to get into and maybe do like Mr. Duncan, ask permission to submit questions for the record.

Chairman JACOBS. Without objection, so ordered.

[No questions were submitted.]

Mr. HOLLAND. Mr. Chairman, I yield back the balance of my time.

Chairman JACOBS. Most generous.

Mr. Rangel?

Mr. RANGEL. Thank you, doctor, for sharing your thoughts with this committee. I used to be chairman of this committee under the previous administration and they wrestled with some of the problems that this administration is having, except they were not nearly as effective as this Administration is, because you can proclaim the savings and they were trying to legislate programs. But I like your way better. [Laughter.]

Because if I understand your testimony correctly, when you cut back and say you are not going to reimburse the doctors, you believe that they are not going to charge the old folks the additional difference, that they are going to accept this as a part of their contribution or voluntarism toward balancing the budget.

Ms. DAVIS. Mr. Rangel, in several of these proposals such as the payments to radiologists and pathologists, we indicated that there would be costs that would be borne by the beneficiary.

Mr. RANGEL. That is the 20 percent.

Ms. DAVIS. That is the normal 20 percent.

Mr. RANGEL. This is going to deter the old folks from getting these X-rays, right, misusing the health system?

Ms. DAVIS. I think that it allows for the fact that, for the first time in a number of years, radiologists and pathologists will be reimbursed on the same basis as other physicians. It also allows us the ability, since there would not be combined billing, to track billing more effectively and to look at the possibility of abuses in terms of the number of X-rays or laboratory procedures that are performed. Currently under combined billing, that simply is not possible.

Mr. RANGEL. This is in the cases where the doctor accepts assignment. When he does not accept assignment, he can charge anything that he wants, is that not so?

Ms. DAVIS. That is correct.

Ms. FEINSTEIN. Mr. Rangel, current law with respect to radiologists and pathologists, in fact, provides an incentive for patients to be hospitalized to get those tests, which is an enormous cost increase to the whole system.

Mr. Rangel. Actually, I am talking about the whole concept rather than—you are not going to grandfather the old folks that cannot afford additional physician fees. I mean, I can see that what you would like to do is to prevent the physician from passing it on, but maybe in Kentucky they handle these things differently, I do not know. But in New York you can bet your life the doctors are not prepared to make this commitment.

I would go along with you if you would grandfather the old folks who just cannot afford to pay an additional physician fee. You just cannot proclaim that you are cutting back reimbursement and talk about a savings. Sure it is a savings. You can cut out the program completely and have a savings.

When you talk about coinsurance in the hospitals, you are saying that people are not going to use the hospitals and not going to use the health system, and coinsurance is a good way to avoid abuse. But you are not talking about protecting those people who are sick and poor and aged and need the system and cannot afford MediGap insurance. If there was some way to grandfather the truly needy—if they still are protected I do not know under the new budget—I think they do not get the same protection they did last year.

But whatever new name you put for these people, why cannot you protect the poor at least and see whether we can penalize the doctors that are overcharging, and allow us to believe that you are just not pulling out figures and saying they are saving—you are saving $2 billion here.

I carried the hospital cost containment bill into utter defeat on the floor. I would have preferred just to have declared a savings with a program. Is there not somewhere that you save $2 billion, a nonexistent program?

Ms. Davis. Mr. Rangel, we looked at a number of ways to try to achieve cost savings, and the fact is these programs have been growing at an escalating rate. We truly believe that the proposal that we have put forward will indeed, as part of the overall economic program, make significant savings. I truly think that while continuing to protect the truly needy and the poor that we must bring inflation under control.

Mr. Rangel. I agree.

Ms. Davis. I am glad we agree.

Mr. Rangel. We do not have any disagreement. Mr. Carter and Mr. Califano all agreed with you, except they did not take the bold initiative to declare the savings that you have without the programs. I do not want to be able to politically balance the budget with savings that we do not have.

You say somewhere with some medicare initiative you save $2 billion. Is that the competition bill that we do not have that you make these savings? How much do you save with the competition reform bill?

Ms. Davis. The competition reform bill is not yet ready to come before Congress.

Mr. Rangel. Do we not have a savings here for it, or a claim?

Ms. Davis. There is no savings proclaimed in the HCFA 1983 budget for competition.

Mr. Rangel. I just saw a fantastic savings. There we are, $2 billion. The budget—the President's budget has it for 1984.

Ms. **Davis**. 1984.

Mr. **Rangel**. Yes. OK. I like your style and I wish that we could do that well with the overall budget. I would hope that the President would be able to say that we have no deficit and in fact interest rates are going to go down, and get on with the legislation. Thank you for your time.

Ms. **Davis**. Mr. Rangel, if all of our proposals are enacted we believe that that will significantly help to decrease our overall budget problems.

Mr. **Rangel**. I only hope that while we are sharing the sacrifice, that somehow you manage to get these old folks that have no money adequate protection. But when you testify that you are relying on the goodwill of doctors to assume their part of the sacrifice, it is frightening. [Laughter.]

Thank you.

Chairman **Jacobs**. Dr. Davis, do I understand from your testimony that when you speak about inflationary costs you mean only inflationary costs to the Government and not to the patient?

Ms. **Davis**. When we speak of inflationary costs?

Chairman **Jacobs**. Yes, when you have referred to curing inflation by these proposals you are talking about the inflationary cost to the Government, not the inflationary cost to the patients, is that correct?

Ms. **Davis**. I think the inflationary cost that we are picking up in the Government is part of the overall inflationary problem as we look at the significant outlays in the medicare program.

Chairman **Jacobs**. But if you remember the point that Mr. Rangel and others have made, you are not really reducing inflation; you are just shifting the cost of it, are you not, from the Government to the patient?

Ms. **Davis**. No, I think we are reducing costs in a number of areas.

Chairman **Jacobs**. You think that doctors, then, as Mr. Rangel suggested, they will be rejoicing in heaven.

Ms. **Davis**. I am not certain that they would be rejoicing, Mr. Chairman, but I believe that they would also join in the economic fight. We believe that the escalation in health costs has been very significant over the last number of years. We also believe that there are a number of efforts now going on in the private sector to try to reduce those costs. And, I believe that altruism is not dead among the physicians.

Chairman **Jacobs**. What sort of correspondence do you have from what spectrum of doctors who have joined your fight? Do you have anything in your files along that line?

Ms. **Davis**. Mr. Chairman, I could not hear you.

Chairman **Jacobs**. You said you were sure the doctors would join the fight against inflation. I assume you mean that they would reduce their charges by the same measure that you reduce your reimbursement. Do you have some market surveys on doctors? Have they written to you? Is there any pledge that you have in hand?

Ms. **Davis**. No, I certainly cannot address what the physicians' actual behavior would be. But let me indicate two things. One is that the medicare physician assignment rate has remained relatively stable over the last several years. The assignment rate for last year was some 52.3 percent, as contrasted to 1976 when it was 50 percent. Thus there is a very slight increase upward.

I think that as the Geminac report recently indicated, more and more physicians are coming into practice, and as we see more physicians in an area, in keeping with other kinds of competition, I think that we will find more of them will be interested in accepting medicare assignment.

We have already found, I know, in New York City that there has been a gericare group of physicians who have banded together to focus specifically on the care of the elderly, and they accept a large number of claims that are under assignment.

Chairman JACOBS. So the answer to my question is emphatically no, you have no organized pledge from doctors who participate to comply with your assertion that they will join in the fight against inflation.

Ms. DAVIS. Individual physicians have joined through the AMA, along with the American Hospital Association and the other health care groups in the voluntary effort. They are working to bring the overall cost down through utilization review efforts and through other things. I do not have a specific pledge from them in terms of how they would react to our specific proposals.

But physicians are educated in very expensive medical centers, many of whom have had a number of Federal dollars subsidizing their programs of education, and I would certainly hope that they will be reflective of that Federal support.

Chairman JACOBS. It is a hope, rather than a possession of pledges.

Ms. FEINSTEIN. Mr. Jacobs, perhaps the absence of outright opposition is tacit approval.

Chairman JACOBS. Do you suppose? Sometimes you do not have to say anything. What is it they used to say here? You vote no and take the dough. Do you remember Arthur Godfrey?

Ms. DAVIS. I beg your pardon.

Chairman JACOBS. Do you remember Arthur Godfrey, the fellow on television?

Ms. DAVIS. Yes, I am old enough to remember him.

Chairman JACOBS. Do you ever see him on TV any more?

Ms. DAVIS. Well, I do not have a chance to watch TV, Mr. Jacobs. [Laughter.]

Chairman JACOBS. Does any of your staff? Do you ever let them off long enough? Do they have their evenings to themselves? God knows Mr. Nixon worked 18 hours a day and anybody in a worthy administration never goes out to eat or watch television or anything like that. I presume that, just as you presume that doctors will make a voluntary sacrifice to help in the fight against inflation.

I have not seen him either. But it seems to me I have heard him on a car radio where you can get a channel-back, a television channel, and he says that the patient has steadily been losing this fight against inflation. The Government reimbursement has placed a constantly greater burden on the patient over the last 8 or 10 years.

Would that assertion be correct or incorrect?

Ms. **Davis**. I have not heard him, so I really could not comment on what he said.

Chairman **Jacobs**. I said would that assertion, even if just anybody said it, be correct or incorrect?

Ms. **Feinstein**. Actually, the value of the deductible has constantly been eroded by its failure to increase.

Chairman **Jacobs**. Yes, I know that. I know what the numbers are. But in terms of patient cost with the inflation or whatever, is that assertion correct or not? Is the patient paying more now, a greater share now, than was the case in 1966?

Mr. **Schieber**. We have attempted to estimate that, Mr. Jacobs, in terms of out of pocket costs by beneficiaries in 1965. This would be for aged beneficiaries. Private out of pocket costs in 1980 had in fact, in real terms, actually gone down. The amount of services gotten by the individual in real terms has almost doubled.

Chairman **Jacobs**. So you would say in essence to these people who write in to all of us and claim that it is costing them more and more of their social security checks and so on that they never had it so good?

Mr. **Schieber**. I think there are two factors at work here. Obviously people are getting more services and people are paying for some of it. Yet in real terms they are paying out less than they had before the inception of medicare.

Chairman **Jacobs**. So it is fair to say that your position is that medicare beneficiaries never had it so good as they do now?

Mr. **Schieber**. I would say that elderly individuals have it better now than they did in 1965 in terms of the amount of health care they are getting and the amount they are paying out of pocket.

Chairman **Jacobs**. I wanted you on the record as saying that.

One last question, Dr. Davis. Here we go again with the PSRO battle, and maybe I should just incorporate by reference everything that you said to me and I said to you a year ago when we talked about this. But the question it seems to me still is important, and that is the gap between the elimination of the PSRO's and the inauguration and indeed the fruits of this nebulous thing called competition.

Could you say about three sentences on that and we will move on?

Ms. **Davis**. I cannot speak on the competition proposal other than to indicate that it will be brought before Congress in about the next month or 6 weeks.

Chairman **Jacobs**. You are speaking to the PSRO's. You will not need them because of the competition.

Ms. **Davis**. I can speak to PSRO's. We believe, that the PSROs that have been effective can continue by working in the private sector. That has been our stand all along—that there have been a number of PSROs that have been ineffective in terms of cost-benefit ratio, and that for us to subsidize the administrative cost for these programs, we think is not justified.

Chairman **Jacobs**. You do not link the elimination of the PSRO to the competition legislation at all? I say, you do not link the proposal to eliminate the PSRO's with the competition legislation and the fruits of that legislation?

Ms. **Davis**. No, I do not.

Chairman JACOBS. It will just work out somehow without the competition legislation if you eliminate the cost of the PSRO's, the reviews, that sort of thing?

Ms. DAVIS. What we are saying is, eliminate PSRO's because they have not been effective in terms of their utilization review. We are suggesting that instead of that we are going to ask medicare contractors to perform utilization review. They already have the data base and rather than regenerating a new data base it would be more effective for us to use the medicare contractors to do this type of review.

Chairman JACOBS. You do recall a year ago you folks were saying that it was because of the competition legislation that we would not need the review programs any more.

Ms. DAVIS. In the long range that is true. But you asked me if I was linking them together here and now.

Chairman JACOBS. I understand that last year you were, if I recall correctly, were you not?

Ms. DAVIS. What I was speaking of last year was the fact that, as competition moves into place, we would not need to have PSRO review.

Chairman JACOBS. In the long run you think it would eliminate the need for such review organizations, but in the short run——

Ms. DAVIS. I think in the long run the competition initiative will.

Chairman JACOBS. I do not know why this should come to light at a health hearing, but if I recall correctly the economists say in the long run we will all be dead.

Ms. DAVIS. I do not think it will be that long a run before competition is fully activated.

Chairman JACOBS. I do not know. If these people cannot afford medical care it can come pretty fast.

I yield to the gentleman from New York.

Mr. RANGEL. Thank you, Mr. Chairman.

I know they are not using the PSRO's now this new competition bill, but are you not linking this with some new private sector utilization review initiative? Is that not the link between eliminating the PSRO with PSAMIURI—is that it? That is the $330 million saving under this overall——

Ms. DAVIS. Yes, Mr. Rangel, there are $330 million in savings there. What we indicated is a large portion of that will be under the medicare contractor's utilization review. But we also acknowledge there will be a private sector initiative which will also aid in reducing costs.

Mr. RANGEL. The chairman was linking it to the bill we have not got, and really that is not what you are doing. You are linking it to the utilization review initiative that we have not got.

Ms. DAVIS. We are developing that initiative right now.

Mr. RANGEL. I know that. I just wanted to help the Chair out.

Chairman JACOBS. The Chair is most grateful to its predecessor. [Laughter.]

Dr. Davis, we are grateful for your testimony. Your testimony and the questions and answers have consumed 1 hour. If this is true of subsequent witnesses we can be out of here promptly at 11 p.m. So I ask that the subsequent witnesses after Congressman Wyden testifies—no, I do not ask. I am just simply saying that the

5 minute rule will be enforced for testimony in chief. As usual, the standing offer of a $1 reward for the person who testifies the most concisely, and therefore briefly, for the day will be awarded at my personal expense. It will be a pleasure to award that $1 at the end of the day. We are keeping track.

Mr. **Anthony**. One final question. I would like to ask, for the record, when we can anticipate the draft legislation being forwarded to the Congress.

Ms. **Davis**. I anticipate that our draft legislation for all of these proposals will be here within the next 4 to 6 weeks.

Chairman **Jacobs**. We thank you very much, Dr. Davis.

Our next witness is Congressman Ron Wyden, and we will not count the time walking up to the witness chair. Congressman Wyden, you are as usual welcome to the committee. Please proceed in your own fashion. We are glad to see a man from the Northwest here to help us.

STATEMENT OF HON. RON WYDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. **Wyden**. Thank you very much, Mr. Chairman. I very much appreciate your giving me the opportunity to testify here today. I realize I was here just a few weeks ago to testify about my legislation to eliminate the requirement that senior citizens go to a hospital prior to entering a nursing home. I very much appreciate your hospitality, Mr. Chairman, and that of the committee, and I in particular want to assure you that I will not be tromping in every week from now on throughout the 97th Congress.

I really wanted to testify today for just two reasons. The first is that I am deeply concerned about the medicare cuts that have been proposed by the administration for fiscal 1983. In fact, I have been concerned about them that I have cosponsored a resolution with my distinguished colleague Mr. Gephardt of Missouri that in effect puts the House on record against further medicare cuts that would adversely affect the health of senior citizens.

Second, I want to testify today because I believe there are alternatives to the administration's proposal, alternatives in effect that are fair, that make more sense. I oppose the proposed cuts because in effect they are unfair and unproductive and really do not add up. They do not add up for the senior citizens, for example. Under the proposed cuts, senior citizens would pay more and benefit less.

They do not add up for the providers. Under the administration's proposal, the providers would get less money and simply more problems.

Finally, the cuts simply do not add up for the health care system as a whole. The medicare system is not in the red because senior citizens need health care. It is in the red because the Federal Government has perpetuated a perverse reimbursement system that actually rewards waste and inefficiency, in effect a reimbursement system under which we hand health care providers a blank check to fill in after the care is provided, rather than negotiating reasonable health care packages in advance.

The result today, Mr. Chairman, is that everyone loses. The Federal Government loses because it has no control over the total tab.

Providers lose because they never get full payment for services provided. The senior citizen loses, in particular the private pay patient who is asked to pick up the extra costs in increased health care bills.

Now, although the administration has said they want to change their reimbursement system, the proposals we have seen to date certainly do not address this problem. Instead, they just shift the burden of health care costs to the tune of some $2.5 billion in 1983 onto the shoulders of senior citizens and providers. In effect what they do is they put short-term budget cuts ahead of real reform.

I would like to just step back for a second and look more closely at exactly what these proposed cuts are going to mean for senior citizens, and that of course, Mr. Chairman, is a particular concern of mine, because I worked with senior citizens before I came to the Congress.

Under the administration's proposal, senior citizens would for the first time begin making copayments for home health care services. For the first time, they would not be eligible for medicare benefits until a full month after they reach the age of 65. In a proposal which in my estimation could lead to real discrimination against older workers, employers would be required to provide health insurance for employees after age 65, rather than rely on medicare as the primary health plan.

In my own home State, I asked the Blue Cross to do a study in Oregon, and in Oregon Blue Cross has concluded that these proposals would mean an increase of up to 20-percent in insurance premiums for all people in order to cover the increased costs of senior citizens.

Now, the impact on providers in my estimation could be equally devastating. Faced with a 2-percent across-the-board cut, many already hamstrung hospitals would have no choice but to take drastic measures to shift the additional cost medicare does not cover to private pay patients, to cut personnel, to begin instituting practices to make sure they get payment before treatment, or simply turn patients away and in effect begin cutting out high-cost programs such as the neonatal units.

Now, I would like to make one point here, Mr. Chairman, that is particularly important in light of what Ms. Davis said. The 2-percent cut applies to efficient hospitals as well as the inefficient wants. So it seems to me you cannot make a case that cutting 2 percent across the board is somehow going to produce efficiencies in hospitals in this country.

Now, I had my staff make a very quick survey in my home town of Portland, Oreg., which I think is representative of hospitals around the country, to really give us an idea of what these cuts are going to mean. Eastmoreland General Hospital in my district has 55-percent medicare population at this point. They would lose $200,000 under the administration's 2-percent proposal. This hospital barely broke even last year. They plan to continue to shift costs to private pay patients and cut back on personnel.

Another hospital, the Providence Medical Center, has written me that they would have to shift $700,000 from medicare to private pay patients. A third hospital, the Holladay Park Hospital, is already shifting 10-percent of the cost to the private pay patients, and this would add up to an additional $200,000 if the 2-percent proposal was enacted.

Finally, Mr. Chairman, it seems to me that under these proposals the hardest hit would be those inner city hospitals. One, for example, in my district that serves 62-percent public patients is already shifting $14 million annually. That is right now, even before the new cuts. It comes to 22-percent of their total revenues.

The additional 2-percent reduction would mean an additional $800,000 to shift. But the problem is, Mr. Chairman, that this hospital has run out of beneficiaries to shift to, 158 employees were laid off last month alone. They have cancelled their building program and they no longer allow elective surgery without prepayment. In addition, individual programs are being carefully scrutinized for possible elimination.

Ms. Davis when she testified earlier said that the 2-percent solution was in effect an interim proposal. It seems to me, Mr. Chairman, that that interim proposal alone will drive Emanuel Hospital out of the inner city and in effect into bankruptcy today.

Mr. Chairman, I think the saddest thing about the administration's proposed budget cuts is that they are both unnecessary and just misdirected. There are solutions to stemming the tide of runaway health care costs, but it seems to me that the butcher block approach to making cuts is not one of them.

The alternatives that really add up, for example, are the kind of things that I have tried to propose in my bill H.R. 5084, which would offer incentives to medical providers to go to the prospective reimbursement system. In effect what we do for the first time is reward them for efficiency.

There are a number of other approaches that are being circulated, and my colleague and friend, Mr. Gephardt, has proposed legislation which many on Capitol Hill are looking at at this point.

Finally, in the resolution Mr. Gephardt and I have introduced we are saying that further capricious cuts in medicare in effect ought to be postponed. There ought to be a moratorium on those cuts and instead what we ought to be looking at are some of these reasonable alternatives that I suggest. I would urge the administration to do likewise, to present us with a plan that we have heard again today, as we have heard so often, is in the works, instead of just telling us about it. We ought to have something so that we can go away from a system that in effect just applies butcher block cuts across the board and does not deal with the fundamental crisis in health care today.

Thank you very much.

Chairman JACOBS. Thank you very much.

Mr. Anthony?

Mr. ANTHONY. Thank you, Mr. Chairman.

I would like to welcome our colleague back before the Ways and Means Committee. Ron, what I do not understand is, I just got through talking to Dr. Davis and she tells me that Eastmoreland General Hospital, Providence Medical Center, Holladay Park Hospital, and Emanuel Hospital can take a 2-percent management initiative, and they will not have to shift that cost to anybody, they will not have to lower their standards, and they will not have to increase their billings to private patients; that sloppy management savings are out there.

I do not understand why those four administrators do not tell you that they can save that money.

Mr. WYDEN. I appreciate the question, Mr. Anthony. I guess the point is, is that nowhere in the administration's package of health care legislation are there incentives for efficiency. That 2-percent cut, for example, applies to the most efficient hospital in the United States just the same way that it applies to the most inefficient.

It seems to me that if you take that kind of approach there is just nothing in the system to have a real set of incentives that are going to finally turn around the situation, and it seems to me that particularly those inner city hospitals that I mentioned that are already, for example the Emanuel, laying off 158 people right now even before the new set of cuts, have nowhere to turn. I think that is why it is high time we look at things like my bill that gives incentives for prospective reimbursement, some of the things our colleague Mr. Gephardt has talked about. That is what we have to look at.

The butcher block cuts that have no incentives for efficiency is just not the way to go.

Mr. ANTHONY. Well, I think you made two strong points. The strongest point you make to me is that the 2-percent cut across the board may sound politically popular, but it does have a built-in unfairness to it in that your efficient hospitals are treated just as the worst-run hospitals.

I think you have brought out a very strong point here. Hopefully, we can make the record very strong in that case. I think there may have been a little glimmer of hope before Dr. Davis gave up her testimony.

Thank you. I yield back.

Chairman JACOBS. Mr. Duncan?

Mr. DUNCAN. I have no questions. I do apologize that I had to step out. I heard your testimony at the last hearing we had and I commend you for your additional testimony.

Chairman JACOBS. Mr. Holland?

Mr. HOLLAND. Thank you very much, sir.

Mr. Chairman, I want to thank our colleague for his continuing interest in this area and his helpful comments here today.

Chairman JACOBS. I echo the sentiments of the rest of the committee. Ron, you have made two very useful contributions—I know this will not be the last one—to the record. I think I speak for most of this committee when I say that we probably think the time has come to look for some places in the budget, maybe south of the border, to find savings for the U.S. Government before we go more deeply into the pockets of the least able ones, namely the medicare patients. You are a champion of them and therefore you are a champion generally speaking.

Thank you very much.

Mr. WYDEN. I appreciate that, Mr. Chairman. I think the only other thing I would add is that if somehow we felt that these cuts were going to take us to a better tomorrow, I mean were really going to lead to some new efficiencies, that would in effect be an argument for doing it. But to just make butcher block cuts that cause pain without setting up a system that finally gives incentives for some real efficiency in medical care just does not seem to me to be the way to go.

I very much appreciate your giving me the chance to come.

Chairman JACOBS. Keep at it.

Our first panel—and by the way, I would ask that the people who are on these subsequent panels, if you see your name is next on the list, would you kind of mosey toward the front of the room, and we will save an awful lot of time in that regard.

American Association of Retired Persons, National Retired Teachers Association, Mr. Hacking; National Council of Senior Citizens, Mr. Clayman. Would you please come forward, identify yourselves, and observe the 5-minute rule in your statements. As I say, those who are subsequently to be called, we can save a little bit of time if you would kind of get on back and ready.

Mr. Hacking, you know the rules of the New York State Athletic Commission or whatever it is. So please proceed.

STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS AND NATIONAL RETIRED TEACHERS ASSOCIATION, ACCOMPANIED BY JACK CHRISTY, LEGISLATIVE REPRESENTATIVE

Mr. HACKING. Thank you, Mr. Chairman. I am here representing the National Retired Teachers Association and the American Association of Retired Persons. These two organizations have a combined membership now of well over 13 million persons aged 55 and older. On my left is Jack Christy, who is one of our health care experts and a legislative representative for us.

With your permission, I would like to submit the associations' statement for the record and proceed to summarize.

The way we deliver and pay for health care services in this country has created extraordinarily powerful incentives to deliver those services in the most costly setting possible, within the walls of the institution and especially within the walls of the hospital. Health care costs in general and hospital costs in particular have been rising at rates far in excess of the general inflation rate since the mid-sixties, with the advent of the medicare and medicaid programs.

Last year hospitals pushed their costs up 19 percent, while the general rate of inflation in the economy was a mere 9 percent. This kind of behavior on the part of health care providers, especially hospitals, is largely responsible for the 15 percent average annual rate of increase in medicare and medicaid program spending. This kind of upward pressure on program costs is what is responsible for proposals such as those we see now from the administration to slash medicare and medicaid program benefits.

The objective in the short run of such proposals is simply to hold down the rate of escalation in program costs. With respect to the specific 15 proposals that the administration has advanced relative to the medicare program, we think each one should be evaluated in terms of its potential for: No. 1, restraining the rate of increase in health care costs; No. 2, promoting less costly alternatives for the delivery of services; No. 3, avoiding mere shifts in costs away from the programs and onto private pay patients or program beneficiaries; and finally, holding down the rate of growth in program spending.

Given these criteria, the administration's package looked at as a whole is quite deficient. Without going through all of these specifics, I would indicate by way of example that the 2 percent reimbursement rate reduction, the indexing of the part B deductible, the introduction of copayments for home health services, the 1983 cap on the rate of increase in physician fees, will result in cost shifting with little or no change in providers' basic behavior.

This package is the administration's short-term plan for health care. We expect their long-range program to contain costs to be predicated on its much talked about but little seen procompetition, voluntary voucher proposal. We expect that to be augmented with a proposal to require a maximum of $26 a day copayment for medicare beneficiaries.

Our reaction to the voucher proposal is one of wait and see. We will not reject out of hand any proposal merely in concept stage that has substantial potential for reducing the rate of escalation in health care costs.

However, with respect to the copayment idea, we are extremely opposed. This is not going to make medicare beneficiaries any more cost conscious than they already are. They are already paying 43 percent of their total costs out of pocket as it is.

We urge this committee to reject the administration's proposed short-term package of medicare benefit cuts and instead do a number of other things. First, we urge this committee to develop an across-the-board cap on the rate of increase in hospital costs and all third party hospital reimbursements, both public and private. If this cannot be done directly, such as the Carter administration attempted to do, then it certainly can be done indirectly, and we can suggest ways of doing that.

We also urge this committee to provide some kind of financial incentive to encourage the States to establish mandatory prospective hospital rate review programs. In those States where such programs already exist, they have demonstrated a good deal of success in restraining the rate of escalation in hospital costs.

We also urge the Congress to avoid premature dismantling of the health planning network through termination of Federal funding, since we are afraid that, if a vacuum is created, there will be an explosion in hospital construction.

Finally, we urge this committee to review thoroughly the provisions of the Internal Revenue Code that result in substantial revenue loss and contribute to the perpetuation of the current system whereby we deliver and pay for services and the incentives this system entails.

That concludes my summary, Mr. Chairman. I thank you and the subcommittee for this opportunity to provide these remarks.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

I. INTRODUCTION

The National Retired Teachers Association and the American Association of Retired Persons (NRTA-AARP) appreciate this opportunity to present our views on the Administration's proposals to further cut the Medicare program in fiscal year 1983. Our Associations strongly support the Administration's goals to revitalize the economy and balance the federal budget over the business cycle. We are deeply concerned, however, about the efficacy of the Administration's policies to accomplish those goals without devastating programs that are essential components of the "social safety net" for our nation's needy, dependent and vulnerable populations.

From the elderly's point of view, Medicare is one of the most important programs in the "social safety net" system. Nevertheless, the Administration proposes $2.5 billion of additional cuts in Medicare for fiscal year 1983; most of which merely shift costs to Medicare recipients already hard hit by last year's huge increases in Medicare deductibles and coinsurance. Our testimony today will focus on the budget cuts in the Medicare program that disturb us most, the reasons for our concern and the consequences of the proposed cuts in this nation's elderly. In addition, we will propose alternative recommendations for reducing federal spending in the health care sector.

II. THE ELDERLY'S INCOME SITUATION AND THE IMPACT OF THE MEDICARE CUTS IN FISCAL YEAR 1982

In 1980, our Associations contracted with Data Resources, Inc. for a study on "Inflation and the Elderly." That study found that the average elderly income (in aggregate terms) managed to slightly exceed the general rate of inflation during the late 1960's thru the late 1970's. Consequently, by 1978, the average income of those over age 65 was about 55 percent of the average incomes of the non-elderly—just about where the elderly's average income had been in 1955. Despite progress made in raising the elderly's average income and reducing poverty among them and the major role in-kind benefits such as Medicare have played in that regard, there is mounting evidence that inflation is wiping that progress away.

Elderly poverty rates, on a steady decline through 1978, increased from 13.9 percent in 1978 to 15.1 percent in 1979; making this the largest increase in the elderly poverty rate since the Census Bureau began collecting such data. We believe that the fixed nature of the elderly's income components as well as their inflexible consumption patterns—particularly for health care—are largely responsible for the substantial increase in the elderly poverty rate.

Moreover, despite the limited growth in the elderly's income during the period 1968–1978, the continuing growth in the elderly's poverty rate in 1980 (15.7 percent) and other statistics demonstrate the economic plight the elderly suffer relative to the rest of the population. For example, in 1979, while only 9 percent of non-elderly head-of-households had annual incomes below $5,000, over 31 percent of the elderly head-of-households had annual incomes below $5,000. Similarly, only 21 percent of non-elderly head-of-households had annual incomes under $10,000, while 62 percent of the elderly head-of-households had incomes below $10,000 per year. Even adding to their income the cash-value of the in-kind benefits the elderly receive does not change the reality that the elderly, as a group, generally subsist on low and in many cases wholly inadequate incomes. In 1980, almost half of all persons age 65 and above—more than 12 million people—had an average annual income of less than $5,000.

The DRI study, supra, projects that the elderly will spend even more of their income on those items which are experiencing the most rapid rates of inflation: food, fuel and utilities and out-of-pocket medical costs. For 1979 through 1985, DRI forecasts an 8.7 percent rise in food at home, a 9.9 percent rise in fuel and a 10.1 percent[1] increase in health care, compared to an 8.7 percent increase in the overall Consumer Price Index.

The Omnibus Budget Reconciliation Act of 1981 authorized $1.5 billion in Medicare cuts for fiscal year 1982. Those cuts included a 27 percent increase in Medicare deductibles and copayments, all of which are paid out-of-pocket by Medicare beneficiaries. Moreover, increases in the Medicare deductibles and copayments automatically increase Medicare supplemental insurance policy premiums; and that too must be paid by Medicare beneficiaries out of their own pockets. Hence, the fiscal year 1982 Medicare cuts substantially increased the elderly's out-of-pocket health care costs.

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[1] This appears too optimistic.

III. EVALUATING THE ADMINISTRATION'S MAJOR PROPOSALS TO CUT MEDICARE IN FISCAL YEAR 1983

The Administration has outlined fifteen proposals intended to reduce Medicare expenditures in fiscal year 1983. The majority of their proposals either directly or indirectly shift costs now being born by the federal government to program recipients, though Medicare contractors and providers take some cuts too.

While the Administration appears to have made its proposals on the basis of program savings alone, our Associations believe that additional criteria are equally necessary for evaluating proposals to cut the Medicare program. First, any proposal to change Medicare must contribute something to restrain the escalating rise in health care costs. Hospital costs, which make up approximately 74 percent of Medicare expenditures, increased 19 percent in 1981. Such uncontrollable costs are largely responsible for the spiralling rise in Medicare expenditures which, in turn, are a source of pressure to cut the Medicare program. Unless such costs can be restrained, Medicare beneficiaries will face continuing efforts to slash the program. A second criteria for evaluating Medicare changes is whether the proposal coantributes to developing quality care. This nation's health care system is bases on the most expensive care possible, acute care delivered in institutional settings. Since the federal government is a major power to help steer our health care system in the direction of less expensive service delivery alternatives.

The third important criteria for evaluating proposals to change Medicare is the avoidance of cost shifting to Medicare beneficiaries. Proposals that simply shift program costs to beneficiaries are based on the notion that the elderly should pay a greater portion of the burden of the program. Such a notion is incongruous because the health care cost spiral is pushing the total cost of health care for older Americans well beyond the growth in their income. Considering the deductibles, coinsurance and premium payments required under Medicare, direct expenditures for health care services exceed the portion of the elderly's annual health care bill covered by Medicare. Beneficiary liability for Medicare Part B physician services alone, is approximately 69 percent of total physicians' charges due when deductibles, coinsurance and unassigned claims are included. The steady erosion in the number of physicians willing to accept assignment (i.e., accept Medicare reimbursement as payment in full) portents continuing increases in beneficiaries out-of-pocket health care expenditures. The last criteria for evaluating proposals to cut Medicare is whether or not the proposal encourages independence, or fosters dependence on some other government support program.

With these four standards in mind, the Administration's major proposals to cut Medicare may be evaluated as follows:

(a) 2 percent reduction in reimbursement to hospitals for the care of Medicare patients (savings, $653 million, 26 percent of the proposed Medicare savings in fiscal year 1983).

It has been reported that this proposal is preferred by the hospital industry to several other proposals for new cost containment regulations which would have focused on costly specific reimbursement items. The larger reduction in program expenditures under this proposal are likely to be illusory, however, because hospitals can easily make up the loss by ordering more ancillary services. Moreover, since the federal reimbursement rate is already 16–20 percent below what hospitals charge their private patients, such Medicare specific cuts will likely shift more costs to private patients.

The Associations believe that this proposal contributes nothing to solving the real crisis facing the Medicare program, namely: restraining the exorbitant increases in hospital costs. Moreover, the likely prospect that the savings envisioned would be shifted to private pay patients, renders it unacceptable on two counts.

(b) Reduce waste and service utilization (savings, $372 million, 14.9 percent of the total projected Medicare savings in fiscal year 1983).

Almost 15 percent of the Administration's fiscal year 1983 savings in the Medicare program are to come from reducing waste in the provision and use of health care services. The Administration proposes to establish objectives (as yet unspecified) for Medicare contractor activities and cooperate with private sector efforts to reduce Medicare patients' average length of hospital stay and other services. In addition, current provisions which waive provider liability for the cost of uncovered care will be eliminated.

The thrust of this initiative is to give Medicare contractors greater responsibility for the identification and reduction of waste in the provision and use of health care services. Yet, despite nearly 9 percent inflation, the Administration refuses to provide additional funds in fiscal year 1983 to pay contractors for this additional responsibility. Moreover, this proposal appears to conflict with another of the Administration's proposals—that is, to eliminate federal funding for Professional Standards Review Organization (PSROs) in July of this year. PSROs are physician-sponsored organizations designed to review the quality and appropriateness of medical care provided to Medicare beneficiaries. PSRO responsibilities include the Administration's objective of reducing unnecessary utilization. Therefore, it is inconsistent for the Administration to propose the demise of federally funded PSROs while at the same time stress the need for increased utilization review to produce substantial savings.

Our Associations are very skeptical about this proposal. Though details are not yet available, it is difficult to see how the large savings claimed are possible merely from "eliminating waste and over utilization". Forced to achieve such savings, Medicare contractors are likely to disallow heretofore covered expenditures or to make the reimbursement process even more cumbersome, difficult and confusing for beneficiaries than it already is.

(c) Forcing employers to pay health insurance coverage for older workers (savings, $306 million, 12.2 percent of the total projected Medicare savings in fiscal year 1983).

By this proposal the Administration intends to make employers' health insurance plan the first source of payment for older workers health insurance claims. The effect of this proposal is likely to be a significant reduction in the employment of older workers.

Medicare, currently provides primary health insurance coverage by paying all covered expenses for eligible beneficiaries, even if the beneficiary is working and covered by a private health insurance plan. Medicare is the first payor and the private plan supplements Medicare. Under this proposal, however, the employer's health plan becomes the first payor.

Making the employers' health insurance plan the primary source of coverage will force up the cost of employing older workers because the employer's health insurance carrier, faced with primary responsibility for covering health claims heretofore covered by Medicare, will insist on being compensated for the additional risk of exposure. Moreover, despite the Age Discrimination in Employment Act's provision allowing employers to provide reduced health insurance coverage for older workers (so long as the employer spends the same amount on premiums for older workers as younger workers) this proposal forces employers to provide health insurance coverage for older workers that is equal to the coverage provided younger ones on the penalty of not being permitted to claim the full cost of health insurance premiums as a tax deduction.

The adverse impact of this proposal on the employment of older workers is totally contrary to the Administration's efforts encouraging older workers to remain in the work force. Moreover, the accompanying loss of income tax and payroll tax revenue to the federal government could more than offset any savings achieved in the Medicare program through implementation of this proposal. Only through increased employment can older workers be expected to maintain financial independence, and, thus, less dependence on government income support programs.

(d) Indexing the Medicare Part B deductible to the consumer price index (savings, $65 million in fiscal year 1983).

Institute copayment for home health services (savings, $35 million in fiscal year 1983).

Establish Medicare eligibility at the beginning of the first full month after attaining age 65 (savings, $145 million in fiscal year 1983).

Taken together, these proposals represent 9.8 percent of the Administration's projected Medicare savings in fiscal year 1983. They seem to be predicated on the notion that the elderly should bear a greater portion of the health care costs under Medicare in order to increase cost consciousness. The elderly are already, however, extremely cost conscious—paying about 43 percent of their total health care expenditures out of pocket. They simply cannot afford to absorb additional cost sharing under Medicare.

In addition to shifting more costs to the elderly, the proposal to institute a copayment for home health care services under Medicare would reverse the trend to make these cost effective services (which serve as an alternative to more costly skilled nursing facility care) more available to Medicare beneficiaries.

In proposing the copayment to "act as a deterrent to unnecessary utilization" the Administration cites certain findings of a recent General Accounting Officer were "questionable". The GAO identified two major reasons for their findings: beneficiaries were not home bound and services provided were not reasonable or medically necessary, especially where aides provided services which supplanted the care giving of family or friends. (Though GAO found that intermediaries deny few claims for payment, the Administration fails to cite that as a reason for their home health proposal.)

Recognizing that the Medicare beneficiary receiving home health services does not make the home bound determination and does not develop the care plan, GAO did not recommend instituting a beneficiary copayment. Rather, GAO—directly addressing the problem found—recommended measures such as clarifying the home bound criteria, including family capability to provide care in the needs assessment process, and instituting more detailed claim reports for intermediary review.

The Administration's proposal to require beneficiary copayment is a misdirected solution to the problems in home health services identified by GAO. Furthermore, the introduction of a copayment for home health services, contrary to the Administration's intended purpose, could result in greater Medicare costs because patients, in order to avoid increased out-of-pocket costs, will choose to remain either in the hospital or a skilled nursing facility.

(e) Eliminate medicare subsidy for private rooms (savings, $54 million in fiscal year 1983).

Raise Medicare physician fee schedules in October instead of July (savings, $210 million in fiscal year 1983).

Cut proposed increase in the physician fee limits from 8 percent to 5 percent (savings, $35 million in fiscal year 1983).

Reduce Medicare reimbursement for Radiologists and Pathologists from 100 percent (when they accept assignment) to 80 percent of reasonable charges (savings, $160 million in fiscal year 1983).

Reduce reimbursement for physicians rendering care in hospital outpatient departments (savings $160 million in fiscal year 1983).

Set single reimbursement limit for home health agency and skilled nursing facility home health services (savings, $18 million in fiscal year 1983).

Taken together these proposals represent approximately 25 percent of the Administration's projected Medicare savings in fiscal year 1983.

While these cuts are directed at providers, it is extremely questionable whether either hospitals or physicians will absorb the majority of the cuts in reimbursements. Rather, the more likely result (and historically consistent result) will be to shift the cost to private pay patients, third party insurers and again, Medicare beneficiaries.

Many of those proposed "provider cuts" are targeted on physician reimbursement. Cost shifting is again expected but, in this instance, will fall directly on Medicare beneficiaries. When only 46 percent of physicians accept Medicare assignment (i.e., accept what Medicare determines to be the reasonable charge for the service or procedure provided as payment in full) it is apparent that the majority of physicians already consider Medicare reimbursement levels to be inadequate. Therefore, reduction in physician reimbursement rates will most likely lead to even fewer physicians accepting assignments and more beneficiaries being required to pay excess charges (in addition to Medicare's $75 annual Part B deductible and 20 percent coinsurance for physician services). Excess charges totaled $1.1 billion in 1979. If Medicare reimbursement rates are reduced further, even fewer physicians will accept assignment and excess charges will dramatically increase—thus, shifting even more health care costs to Medicare beneficiaries.

The proposal to reduce reimbursement for physicians rendering care in hospital outpatient departments could have additional adverse consequences. This proposal is based on the assumption that physicians providing services in hospital outpatient departments have lower overhead costs than their colleagues in private offices and therefore, should receive a lower reimbursement. The Administration contends that Medicare is presently reimbursing twice for the overhead cost of the hospital outpatient department—once through hospital reimbursement and once through physician reimbursement. This proposal is intended to eliminate the double payment.

The basis of the Administration's proposal is valid only if physicians who practice in hospital outpatient departments do not have a private practice office. In many instances, however, this is not the case. Under this proposal physicians with overhead costs for private offices who presently spend part of their time in hospital outpatient departments may decide to cease their outpatient department work in favor of private office visits, where overhead costs are included in Medicare's reimbursement. If enough physicians make this decision, staffing of hospital outpatient departments could be seriously eroded. Medicare beneficiaries seeking hospital outpatient services might be denied access to this type of care and, thus utilize the higher cost services of a hospital emergency room or seek admission to the hospital on an important basis. In this worst case example, Medicare costs would substantially increase.

Later this year, the Administration will propose measures to improve market forces in the health care industry and in the Medicare program. No costs or savings from these efforts are assumed until 1984 and as yet, no details have been specified. Since the program is likely to include, however, a voluntary Medicare voucher plan and a new Medicare copayment, the Associations feel that a comment on this proposal is appropriate at this time.

The proposal, as we understand it, includes a voluntary voucher plan and a new Medicare copayment of 10 percent of the daily cost of a hospital room, up to a maximum of $26 per day, for the 2nd through 60th of hospitalization.

Under current law, Medicare Part A pays for all covered hospital services from the 1st through the 60th day of hospital confinement after payment of the hospital deductible of $260. The Administration proposed to significantly increase recipients' out of pocket costs by requiring an additional charge of up to $26 per day for the 2nd through 60th day of hospitalization.

For persons 65 years of age and over, the average number of hospital days per person with one or more hospitalizations is eleven days. Hence, instead of a $260 deductible under current law, the average Medicare claimant will pay $560 * * * $260 more * * * under the Administration's proposal.

Medicare recipients, already hard hit by last year's huge increases in Part A and Part B deductibles (27 percent) and coinsurance, simply cannot absorb another precipitous increase in out of pocket costs for Medicare.

The Administration is selling its competition proposal by adding a catastrophic stop loss provision that would indemnify Medicare beneficiaries for all covered hospital and physician costs above $2500 or $3000 per year. (The stop loss protection does not include expenditures incurred for noncovered costs such as: outpatient prescriptions, eyeglasses, nursing home care, etc.)

While the stop loss protection proposal is a significant benefit to the 2 of 3 percent of Medicare patients requiring long term, acute care hospitalization, it does not provide any benefit to the 97 percent of Medicare beneficiaries who will be paying huge additional out of pocket costs for hospitalization.

To the extent that the voluntary Medicare voucher proposal contributes to reforming this nation's costly health care system, the Associations welcome the dialogue it will create. At this point, however, we are skeptical about any plan that includes substantial new out of pocket costs for Medicare patients and illusory catastrophic stop loss protection.

IV. BUDGET ALTERNATIVES THAT ALLEVIATE THE PRESSURE FOR CUTS IN DOMESTIC PROGRAMS AND THAT ADDRESS THE UNDERLYING CAUSES OF HEALTH CARE INFLATION

The Associations believe that changes in the Medicare program cannot be predicated solely upon reducing the looming deficits in the federal budget. Considering the deficits, we recognize the intense pressure to slash Medicare costs, indeed the pressure to slash the entire domestic program budget, is caused, in part, by the huge deficits projected for this, and the next several fiscal years. The economic recovery envisioned by the 1981 Economic Recovery Tax Act is sputtering and will likely falter because of the overly generous provisions of that Act. The federal government cannot relinquish huge sums of revenue over the next several years, significantly increase spending for defense, and expect the budget to come into balance. Something has got to give. The Associations strongly urge the Congress to modify or repeal provisions of the Economic Recovery Tax Act with a view towards: tightening tax loss leasing provisions, strengthening the windfall profits tax on oil, postponing the cuts in personal income tax rates that are scheduled to take effect in July, 1983, and eliminating certain tax expenditures which do not contribute to larger economic goals.

Furthermore, the Associations believe that changes in the Medicare program must be evaluated on criteria that address the serious health cost in this country. The Federal Government, as a major purchaser of health care services, cannot shrink from its responsibility to abate explosive inflation in the health care sector. The record increase in hospital cost in 1981 is a major factor in the inordinate rise in Medicare expenditures. Since approximately 74 percent of all Medicare expenditures are for hospital costs, the Federal Government has the market power and the financial interest to abate hospital cost inflation.

The Associations have long urged the Congress to place Federal limits on increases in hospital revenues per admission. Such an across-the-board approach would not single out Medicare or Medicaid beneficiaries for special restrictions. Time and again, experience has demonstrated that Medicare-Medicaid specific aproaches to hospital cost containment merely leads to cost shifting and thus, no reduction in the rate of increase in total hospital costs.

Unfortunately, Congress has rejected the imposition of uniform, across-the-board limitations on increasing hospital costs. Alternatively, the Associations recommend that Congress actively encourage the States to adopt mandatory hospital rate review programs. Such programs have been successful in the six States that have them because they reduce both public and private sector outlays for hospital care. In addition, we urge Congress to direct the Federal Government to share a larger portion (perhaps one-third) of the savings in Medicare and Medicaid costs that are achieved through rate review programs in the States. Providing financial incentives for States to initate effective hospital rate review programs could produce substantial savings to both Government and private purchasers of hospital care services.

The amount of revenue lost from tax expenditures has increased faster than the increase in direct Federal outlays in recent years. This rapid increase in the growth of tax expenditures focused a growing general awareness on health insurance related tax expenditures as just another form of Federal subsidy in the health care sector. Though somewhat less apparent than direct Federal outlays, tax expenditures are indirect, subtle, but susbtantial subsidies that create powerful incentives for particular behavior. Unilke Medicaid which is a direct Federal health subsidy benefiting the poor, health insurance tax expenditures are indirect Federal health subsidies that, according to the Department of Treasury, primarily benefit the middle and upper income groups; i.e., 57 percent of the tax expenditure from the exclusion of employer paid health insurance premiums benefits people earning more than $20,000 per year.

Spiralling health care costs are a major source of the pressure to cut the Medicare and Medicaid programs. Between 1975 and 1979, Medicaid expenditures grew at an average rate of 13 percent per year, Medicare expenditures at 17 percent per year. According to the Department of Treasury's estimate, health insurance related tax expenditures grew at an average annual rate of 19 percent per year during the same period.

It is grossly inequitable to continue cutting direct Federal health subsidies, like Medicare and Medicaid, and ignore the fastest growing Federal health subsidy—health related tax expenditures. The availability of the tax expenditures that permit employers to deduct the full cost of their health insurance premiums as an ordinary and necessary business expense and that excludes employer paid health insurance premiums from employees taxable income, should be made contingent upon restraining reimbursement behavior on the part of the private third party payors.

These health tax expenditures have created powerful incentives that have encouraged first dollar, broad based insurance coverage primarily focused on acute care delivered in expensive, institutional settings. The unconditional, unlimited tax free treatment of employer contributions for health insurance coverage is a great benefit to both employers and employees; employees bargain for more comprehensive health insurance coverage with low cost sharing liability and employers substitute such fringe benefits for (increased) wage demands. It is a mutually convenient arrangement that has led to comprehensive health insurance coverage.

While the Associations recognize the laudable purpose behind these health insurance incentives given the health care system's woefully inadequate and cost promoting reimbursement mechanism, such incentives have promoted excessive increases in health care costs, including the costs of the Medicare and Medicaid programs. Therefore, the Associations support the concept of making the deduction of employers' health insurance premiums (as an ordinary and necessary business expense), and the exclusion of employer premiums payments from their employees gross income contingent upon cost restraining behavior on the part of the third party payors.

The Associations believe that making the employers' and the employees' health insurance tax preference conditional on their group health insurer's adherence to Medicare established hospital reimbursement limits and the availability of a variety of health plans, including HMOs, will create incentives to hold down skyrocketing hospital costs. By conditioning these tax expenditures in such ways, the powerful incentive to develop more comprehensive health insurance coverage (broad, first dollar coverage with low deductibles) will be reduced and pressure from employers and employees on carriers and providers will hasten the development of less expensive health care delivery systems.

On the supply side of tax expenditures, sever and immediate limitations should be placed on the tax exempt status of hospital bonds. (For hospitals able to demonstrate the need for new construction in a growth area, this subsidy could be retained or gradually phased out.) Approximately half of the funding for hospital capital projects comes from tax exempt bonds ($5.1 billion of these bonds were issued in 1981). The direct Federal revenue loss from all outstanding hospital bonds in fiscal year 1982 will be $700 million. Our Associations seriously question the efficacy of this subsidy which allocates resources on the basis of a hospital's financial standing rather than the need for such facilities. Moreover, the magnitude of this subsidy promises to substantially increase should local health planning and the certificate of need process be phased out as the Administration has proposed. In those areas of the country that are already overbedded, tax exempt hospital bonds further escalate Medicare and Medicaid reimbursement levels for empty unneeded beds. Every $1 saved by borrowing hospitals costs $1.33 in lost Federal revenue.

V. OTHER BUDGET PROPOSALS THAT WILL INFLUENCE MEDICARE OUTLAYS

The Association believe that this Committee should be aware of other budget proposals that, while not in the Medicare program directly, nevertheless if approved by the Congress will clearly escalate Medicare outlays.

First, the proposed phase-out of federal support for local health planning in fiscal year 1983, portends substantial increases in health care costs. In essence, the Administration is offering health care competition in lieu of regulatory "barriers" in the marketplace. While we believe that incentives can change the health care delivery system in constructive ways, we seriously doubt that "competition" in the health care sector alone can provide the strong constraining mechanisms required to control spiralling health care cost inflation. We question the wisdom of dismantling the only proven, community-based cost-containment program in place, before the efficacy of "competition" to control costs has been demonstrated. The Associations view health planning and the certificate of need process as a viable state and local decision-making process with demonstrated success. It remains one of the few tools government and health care consumers have in the battle against rising health care costs.

The chief concern among supporters of health planning as well as those who subscribed to the competition theory, is that in the Administration's haste to eliminate health planning and deregulate the health care marketplace, a void will be created and costs will skyrocket—especially Medicare cost reimbursement for hospital capital expenditures—before an effectively competitive marketplace can be achieved.

Given the current reimbursement system, hospitals in particular have been interested in renovating and expanding their facilities more frequently in recent years. The tendency now is to update or replace plant after approximately fifteen years compared to 20–25 years in earlier periods. These pressures are likely to accelerate in the absence of community wide planning and (certificate-of-need) reviews. The accelerated depreciation allowances for capital spending, approved last session, are likely to compound this problem in the absence of local spending review requirements. Such tax changes would allow hospitals to achieve faster write-offs under a less regulated environment without regard to need. Estimates are that over the next four years there will be a 50 percent increase in capital construction ($10 billion more) if the phase-out of local planning is approved.

The direct cost of the Medicare program will be significant. An American Health Planning Association (AHPA) survey of hospital bed expansion projects (1980), projects a minimum of 3,000 additional beds per year and a maximum of 16,000 beds per year will be added to present hospital capacity if health planning is eliminated. In beds alone, this will cost the federal government $127 million a year (based on intermediate estimate, assuming a 74 percent occupancy rate), a majority of which will come out of the Medicare trust fund. Total federal costs could go as high as $256 million per year. Again, this is for additional hospital beds only. It does not include estimates for additonal renovation, replacements, equipment, nursing homes and other elements of the certificate-of-need process. When these additional elements are included, the cost to the Medicare program, the U.S. Treasury, and the public will obviously be even greater.

Unfortunately, the health care industry's Voluntary Effort (VE) to contain health care costs has not even achieved its own very modest goal. To eliminate federal support for health planning just a few years after much of the machinery for the process is finally in place, epitomizes waste in government spending. The Associations urge the Congress to maintain a viable local health planning presence and capability that will help reduce Medicare outlays in fiscal year 1983 and beyond.

Finally, the Associations urge the Congress to provide elderly Medicare beneficiaries equal access to Health Maintenance Organizations (HMO) through changes in the way HMO's are reimbursed for services. This would result in real, long-term savings to the Medicare program. As individuals, the elderly for the most part cannot enroll in HMOs. Changing reimbursement from a cost plus to a prospective, prepayment basis for Medicare beneficiaries, with required open enrollment periods, would act as a powerful incentive for the development of the HMO option for all segments of the population. Clearly, retrospective, cost-based reimbursement is not financially attractive nor viable for all but the largest and richest HMOs. Without making these reimbursement changes, the elderly will, for the most part, continue to be denied access to HMOs and Medicare outlays will continue to escalate at unnecessarily high rates.

VI. CONCLUSION

In summary, while the Associations support the Administration's effort to reduce federal expenditures, balance the budget, reduce inflation, and revitalize the economy, we believe that the Administration's budget priorities and policies do not contribute much to achieving these goals. We do not believe that emasculating domestic programs in tandem with massive tax cuts will abate inflation, generate economic recovery or reduce the federal budget deficits.

For the most part, the Administration's proposals to cut Medicare only further serve to exacerbate the elderly's out-of-pocket costs for health care, without providing any possibility of controlling spiralling health care inflation in the future. We urge the Congress to look seriously at tax expenditures as a means for controlling the rate of escalation in hospital costs and for providing incentives for more prudent purchases of health care coverage. The Administation's proposals to substantially cut Medicare benefits through increased cost-sharing requirements are not justified in isolation. Efforts to restrain health care costs should not be Medicare and/or Medicaid specific, but across-the-board. The poor and the elderly should not be placed at a competitive disadvantage in accessing and paying for health care services.

Chairman **Jacobs**. Four minutes, 8 seconds. Congratulations.

Mr. Clayman?

STATEMENT OF JACOB CLAYMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY JANET MYDER, RESEARCH SPECIALIST

Mr. **Clayman**. I do not think I can beat that. I surrender.

Chairman **Jacobs**. You try now.

Mr. **Clayman**. My name is Jacob Clayman——

Chairman **Jacobs**. It is not long in the fair lexicon of youth, sir. Please proceed.

Mr. **Clayman**. My name is Jacob Clayman and I am president of the National Council of Senior Citizens. Our organization was born 20 years ago and the idea that gave it birth was medicare. We were in the middle of the fight lock, stock, and barrel at that time, and a ferocious fight it was. And finally it came to pass that medicare was with us.

This may explain why we so vigorously oppose those who would attempt to dismember in one form or another, inch by inch, the whole medicare system. And we believe that the administration's proposal is the beginning of that road, which we refuse to travel. And we will fight it with our last breath.

I think you ought to know that the senior citizens of America in terms of health care have a special posture in our country. Medicare, which we applaud, which we revere, and which we understand, however, is a very modest program. It never got beyond the realm of modesty.

Every senior citizen spends roughly—not every one, but on the average—$1,000 a year on health care above and beyond medicare. Medicare takes care of, some say 40 percent, some say 38 percent of health care costs. Whatever the figure is, it is a relatively modest item in the total payment of health care for the elderly.

I think you ought to know, too, that the health care payments made by senior citizens is three times that which is paid by the rest of the population. And so you can understand from what I now say the anxiety that is felt in America by senior citizens as they see this new effort to change the figures, to cut back on health care.

I think I will not refrain from taking a few seconds to say that the greatest thing that has happened in the last half of this century, perhaps one of the greatest things that has happened in the last half of this century, is the birth of the concept of health for the aged, because from it may ultimately come the realization of the concept that proper health care belongs to the entire population.

Cutting $2.5 billion from the 1983 fiscal budget plainly, simply, directly means hardship for senior citizens. There is no other result that I know. And given that hardship, we call upon this committee to deny, refuse, repel the recommendations made by the administration that medicare be cut in this Congress.

Now, you see, Mr. Chairman, I have kept within my 5 minutes, and in the process of keeping within my 5 minutes I forgot to introduce Janet Myder, who sits beside me and who is one of our research specialists. And I did not want to omit it.

Chairman JACOBS. You are a fortunate man, sir.

Mr. CLAYMAN. Yes, I am fortunate, more than you know.

Chairman JACOBS. Really.

Mr. CLAYMAN. Not in that tone of voice, sir.

Chairman JACOBS. Actually, you said you could not do as well as Mr. Hacking, but you did 1 second better.

Mr. CLAYMAN. You mean I have time coming?

Chairman JACOBS. No. You might have a dollar coming. I will let you know at the end of the day.

[The prepared statement follows:]

STATEMENT OF JACOB CLAYMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, Members of the Committee, I am Jacob Clayman, President of the National Council of Senior Citizens. The National Council is a non-profit, non-partisan membership organization with approximately 4,000 affiliated clubs and state and area councils representing over 4 million elderly persons in all 50 states.

We appreciate the opportunity to appear before this subcommittee today because we are particularly concerned about the health of elderly people. Health care has been a major focus of NCSC's activities since it was founded 20 years ago during the development of the original Medicare proposals.

Over the years, we have been concerned about the elderly's access to adequate health care services at reasonable cost. We recognize that, while Medicare has undoubtedly improved the health status and extended the lives of countless older Americans, the program has serious flaws, and it needs to be improved. However, we believe that the Reagan Administration did not have the improvement in mind when it designed its fiscal year 1983 Medicare budget proposals.

Today, the elderly are incurring increasingly greater financial burdens for receiving health care services that do not even meet their total health needs. The President, through his fiscal year 1983 budget, is proposing to make these burdens *much* heavier. Mr. Chairman, the National Council of Senior Citizens is very concerned about these proposals.

We believe that the proposals will impose unreasonable financial burdens on elderly persons and will threaten their health status; will shift costs to other health care consumers; are based on misguided and misleading assumptions; and offer no improvements in the health care system, but have the potential to exacerbate existing problems of access, cost, and quality.

Mr. Chairman, these Medicare proposals have been made in the context of a Presidential economic "recovery" plan. Under this plan, the budget proposals have implications for the health and well-being of nearly all Americans of all ages. I believe therefore that it is relevant to mention some of our general concerns today before I discuss the impacts NCSC anticipates the Medicare proposals will have on the elderly.

The National Council of Senior Citizens has fundamental misgivings about this so-called economic "recovery" program. We believe that our country's economic condition is worsening under the President's program. We believe that the extent of the proposed budget cuts for fiscal year 1983 is due, in part, to the damage this program has done during the past year.

The results of the Reagan Administration's first year of effort are becoming more evident every day: Too many people, blue and white collared, are losing their jobs and are unable to find employment. Too many families, young and old, low- and middle-income, are finding it difficult to make ends meet. Too many elderly who retired on incomes they once thought to be sufficient are finding these incomes too low in today's economy. Too many small businesses are failing; even some large ones are resting on shaky ground. Too many people are unable to buy homes, or even cars, because of prohibitive interest rates. Too many business people do not have enough faith in our economic recovery to invest in the future. And the list goes on.

Added to this economic program's failure to improve the economy are the painful burdens imposed by the President's budget. Again, the NCSC has fundamental misgivings about the Administration's budgetary policies. A close look at these policies demonstrates who really bears the burden of the federal budget cuts.

When the President first took office, he set a course toward "balancing the budget." It was not very long before we discovered what that really meant. Since the Administration raised Defense Department spending in fiscal year 1982 and decreased federal revenues through the tax cut, the only area left for the President to cut was domestic spending. So massive cuts were made in programs that help people.

Last year many representatives in Congress supported the President's program; they were willing to give the President a chance. This year, however, things have to be different. We all should have a picture of the program's impacts on people like the elderly. However, we need forums such as this hearing today to clarify that picture for all to see.

One year ago, this subcommittee met to hear testimony on the proposed fiscal year 1982 Medicare program cuts. Many of us recognized then that the cuts were part of an economic program that would not work. In addition, we felt that the cuts would unfairly penalize the beneficiary and would undermine well-planned policies designed to offer less expensive alternatives to institutional care.

Fortunately, the Congress recognized the benefits of maintaining such provisions as eliminating the three-day hospitalization requirement for home health care eligibility under Medicare A. They also saw the benefit in lifting the 100 visit cap on home health visits. These and several other Medicare provisions were retained, although the President wanted to eliminate them, regardless of their merits.

However, a review of the 1981 Omnibus Reconciliation Act shows that Medicare beneficiaries nevertheless are paying dearly for the fiscal year 1982 budget cuts. Parts A and B deductibles and Part A co-insurance levels have increased. (Under Part A the increase was $32 higher than scheduled under the law before the budget was passed.) Part B open enrollment and deductible carryover were eliminated. All of these provisions have increased the financial burden of the beneficiary.

I am very distressed that, in spite of the deep cuts made in the fiscal year 1982 and in spite of the evidence that the strategies adopted last year are not improving the economy, we have to meet again this year to discuss deeper and potentially more harmful cuts. I am somewhat optimistic, however, that the budget process outcome may be better this year in certain areas such as Medicare. I base this prediction on two factors:

1. The proposed Medicare cuts are so outrageous, so punishing to the elderly, so fraught with misguided assumptions, so clearly the wrong solutions to problems, and so likely to create even greater problems, that no one should take them seriously.

2. To allow the President to make deeper and deeper cuts in domestic spending as he tries to catch up with a deficit that is widening because of his own policies is unconscionable. The American people should not allow the President to cling with "unwavering adherence" to policies that not only are not working, but are hurting millions of innocent people. I know that the elderly will not and I sincerely hope that the Congress will not.

Unfortunately, there are people who may not see the Medicare proposals as I have described them. I am sure, however, that some discussion of these proposals and their expected impacts will demonstrate that these cuts should not be made.

I would summarize the Medicare proposals in this way:

They ignore the critical problems of delivery and reimbursement in today's health care system.

They are designed simply to shift increasing costs away from the federal budget to the senior citizens and to the private sector.

Their goal is to "protect the federal budget against * * * excessive inflation."[1] In pursuit of this goal, they would risk the beneficiaries' protection against excessive health care inflation and their protection against illness.

They will not reduce the acceleration of health care costs, and may encourage further acceleration.

Through its Medicare proposals, the Administration is attempting to address the very serious problem of increasing cost for our nation's health care. However, these proposals would not institute reimbursement reform to reduce or control costs; they would not change benefit coverage to better meet the elderly's needs; they would not improve access for the elderly, or anyone else. Instead, the proposals would shift financial responsibility elsewhere for the same troubled health care system which now plagues us and our economy.

We believe that these proposals carry this message: "Health care costs too much; the federal government is spending too much money on the elderly's health care; therefore, to save the government money, someone else will have to pay." In most cases the "someone else" will be the Medicare beneficiary. This is no solution to the problem. The elderly currently have difficulty financing their health care in spite of Medicare.

Of all population groups, the elderly are at greater risk of needing health care services and of incurring large health care bills. Medicare covers only about 38 percent of seniors' medical expenses. Frequently needed and expensive services such as outpatient prescription drugs, chronic care, dental and eye care, and preventive services are not covered. In addition, as inflation erodes Medicare benefits, increasingly greater portions of medical costs must be paid out of the elderly person's own pocket. The burden of paying for care can be devastating to the limited incomes of most elderly people.

The median income in 1980 for males over age 65 was $7,342 and for females $4,226.[2] Four million elderly persons, or 16 percent of the population over the age of 65, lived below poverty ($3,941 for one person, $4,954 for two persons) in 1980 and another 2.5 older Americans lived in "near poverty" (at incomes $4,926 for one person, and $6,193 for two persons) during that year.[3] These numbers have increased during the past two years and now about one-fourth of all elderly people live near or below poverty.

Inflation in the cost of basic goods and services has seriously eroded seniors' incomes and the inordinately high rate of medical care inflation is a particularly serious problem. In 1981 inflation in health care was 12.5 percent, well above that of 8.9 for other goods and services, and well above the indexing meant to keep Social Security benefits abreast of inflation. This 12.5 rate was the highest health care inflation rate in about 20 years. The rate continues to rise in 1982 at a double-digit rate, the only CPI category to do so.

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[1] U.S. Department of Health and Human Services Fiscal Year 1983 Budget Document Summary, page 39.

[2] Current Population Reports Services P-60, No. 127, "Money Income and Poverty Status of Families and Persons in the United States: 1980," U.S. Department of Commerce, Bureau of the Census, August 1981.

[3] Ibid.

Factored into the 1981 medical inflation rate are these painfully high rates of increase: Hospital room rates, 17.0 percent; prescription drugs, 12.6 percent; physician fees, 11.7 percent; and dental services, 10.2 percent.

These excessively high rates of inflation force the elderly to pay increasingly greater portions of their incomes for health care. Seniors feel the impact whether or not services are covered by health insurance. For uncovered services senior citizens will pay more and more out of pocket, at the expense perhaps of other needed goods or services.

Inflation rates in covered services also exact heavy tolls on the elderly. As costs increase, the elderly pay higher copayment and deductible rates. For example, hospital room rates are reflected in the $260 deductible beneficiaries now pay for each benefit period under Part A. In addition, as inflation causes the federal government to pay disproportionately more for certain services, such as hospital care with a 17 percent inflation rate, coverage for other services such as chronic care must be foregone.

This medical inflation rate is totally unacceptable, and it shows no signs of slowing. It creates such serious problems for our country's economy, for the elderly, and for all health care consumers that it requires immediate action. What is the immediate action proposed by the Administration? Ignore the problems and make the consumer pay more!

What does the Administration propose for the long term? Market reform. The President would create a competitive health care market by forcing consumers to bear greater financial responsibility for their health care. As the competition theory goes, these consumers would force providers to become efficient and to deliver services at lower cost. Significant elements of this consumer cost-sharing concept are embodied in the fiscal year 1983 Medicare budget proposals.

The NCSC does not agree with these market initiatives and we believe that not only will they be ineffective, but they will also be harmful to at-risk groups such as the elderly. Furthermore, by the Administration's own estimates, no change is expected from any of its proposed market initiatives until at least 1984. Even if such reform were to be effective, we still would face a few more years of increasing health care costs and increasing out-of-pocket expenditures.

Hearings have been held, and more will be scheduled, to examine the Administration's long-range plans for both the Medicare program and the health care system. Today, and in the coming weeks, we must focus upon what the Administration has proposed for the short term. NCSC believes that reducing benefits and increasing cost to the beneficiary is wrong. For the purposes of illustration, I will highlight what we believe are the fiscal year 1983 budget proposals which are potentially the most harmful to the elderly.

(1) *Physician fee schedules.* These schedules are the basis for Medicare B reimbursement of physician services. The Administration proposes to postpone the 1982 update, due in July, until October. In addition, the Administration would limit the annual fee increase now eight percent, to only five percent, until its own "competition" legislation is enacted.

Although there may be administrative merit in updating physician fees on a fiscal-year basis, these two proposals, in combination, will be very damaging to the elderly.

Currently, only about one-half of all physicians accept Medicare Part B assignment. That is, they do not accept the rates which Medicare considers customary and reasonable for their services. Instead, the physicians bill the patient directly and at higher fees. The patient receives reimbursment from Medicare and is responsible for paying the physician this amount plus 100 percent of the charge which exceeds the Medicare allowed rate.

Physicians are reluctant to accept Medicare assignment because the fee schedule does not adequately reflect the current charges, and thus the reimbursement levels are too low. To postpone the annual update of fees, and to limit this increase would further discourage physicians from accepting assignment. The discrepancies between current and reimbursable charges will be even greater than they are now, and the patient will have to pay the difference.

The Administration apparently believes that by slowing the rate of reimbursement for physicians' services, the rate of fee increases for services will also be slowed. Inflation in physicians' fees may be too high at the current 11.7 percent but the proposed increase of 5 percent is far below even that of the current CPI. Physicians cannot be expected to render service to patients and accept reimbursment levels they consider too low.

This proposal could decrease the number of physicians who are willing to accept Medicare assignment, resulting in an increase in the beneficiaries' out-of-pocket costs as physicians pass the excess fees on to their patients.

(2) *Part B deductible.* The Administration would index this deductible to the CPI. The deductible, now $75 per year, was increased by 25 percent, effective January 1, 1982, as part of the Omnibus Reconciliation Act of 1981.

To increase the deductible again would further erode the elderly's capability to pay for health care and would potentially discourage them from receiving needed services.

This proposal can also be counterproductive. The Administration hopes to save money. However, since meeting the Part B deductible gives the elderly access to physician's services, the size of the deductible may cause beneficiaries to postpone or neglect seeing their physician until they are very ill requiring hospitalization. Such an outcome is undesirable both to those who care about the well-being of the elderly and to those who are concerned about the federal budget.

(3) *Pathologist and radiologist reimbursement levels.* The Administration would reduce reimbursement for these physicians from the current 100 percent to 80 percent. The 1980 Budget Reconciliation Act provided for this 100 percent reimbursement to encourage assignment. Whatever the justification for changing the reimbursement rates again, we believe that the impact will be greater on the patient than on the physician.

This loss of reimbursement will discourage physicians from accepting assignment. The difference between Medicare reimbursement levels and the physician's charges, in addition to the twenty percent required co-payment, will very likely be passed on to the patient, increasing his/her out-of-pocket costs.

(4) *Home health reimbursement.* In fiscal year 1983, the Administration would require Medicare beneficiaries to pay part of their home health care which is now reimbursed fully for unlimited visits.

The current reimbursement levels became effective in July, 1981 as part of the 1980 Omnibus Reconciliation Act. These provisions were approved after a long, thoughtful process with public input, to encourage the use of non-institutional services. They are positive steps for the elderly to receive home care, and for the Medicare program to save money which would otherwise be spent on institutional care.

The Administration states that this co-payment is a way to reduce unnecessary visits. NCSC believes that the outcome of this proposal will be a reduction of necessary visits for those who cannot afford the co-payment, a loss of benefit for all beneficiaries, an impediment to receiving needed services, and a potential for unnecessary use of covered services, such as hospital care. It might also increase the length of hospital or skilled nursing facility stays.

(5) *Hospital reimbursement.* In fiscal year 1983 the Administration proposes an increase in reimbursement that is two percent lower than that which would occur under current law. Although hospitals would be prohibited from passing this loss directly to those Medicare beneficiaries, the proposal would have negative impacts on non-Medicare patients and indirect impacts on the Medicare patients as well.

The Administration expects to achieve "program economies" through this proposal. The "economies" may reduce Medicare expenditures but they will shift costs elsewhere. Third party insurance payers or persons who pay their own bills may be charged higher fees as the hospital tries to recoup its loss of Medicare reimbursement. A hospital may institute its own "economies" with negative results. For example, hospital employees may be denied the salaries or the benefits they deserve, and this can be reflected in the care rendered.

Under such a proposal, there is no guarantee that what the Medicare program saves will not show up as a cost elsewhere in the system. Also there is no guarantee that a hospital will adopt economically efficient behavior as the Administrations presumes it will.

(6) *Working aged.* The proposed acction would require that employer sponsored group insurance be the primary payer for the working aged.

Even more serious than the shifting of costs to the private sector and the possible loss of benefits or increased costs to the elderly, is the possibility of increasing discrimination against the elderly person who desires to work.

American businesses are feeling the economic pinch, and when given the option of hiring a person who potentially can cost them more money (because insuring the health of the elderly *is* expensive), we may see choices which are not in the best interests of the working elderly. This policy could also be contradictory to the attempts to keep older persons as productive as they would like to be.

(7) *Physician services in hospital out-patient departments.* The reimbursement levels for these physicians (for example, cardiologists, oncologists, physiatrists, etc.)

would be reduced on the assumption that Medicare is paying twice for overhead costs—once to the physician, as reflected in his/her fees, and again, to the hospital as reflected in its routine costs.

As written, this proposal could increase the costs to the patient since the physician who does not accept assignment and wishes to recoup his/her loss of reimbursement could simply charge the patient a higher fee. The proposal would also encourage those who now accept assignment to refuse assignment.

(8) *Eligibility date*. Under the proposal, persons turning 65 years of age would be eligible for Medicare coverage on the first day of the next month after their birthday. (Now they are eligible at the beginning of the month during which their birthday occurs).

This proposal would further shift costs to the private sector in areas where existing coverage is not automatically extended to the end of the month. It would also be a serious problem for the unemployed and the uninsured who will be without health insurance and therefore at risk for a longer period of time. (In the latter cases, the cost of care could be shifted to states or communities.)

(9) *Out-patient physical therapy*. The proposed action would reduce from $50 to $100 the annual limit on reimbursement for physical therapy provided by an independently practicing therapist.

The limit was raised from $100 to the current $500 by the Omnibus Reconciliation Act of 1980. This change was effected to increase beneficiaries' access to service and to align the limit more realistically with today's market. Even so, $500 buys very lettle service since physical therapy, unlike many services, must be administered in a series of treatments in order to achieve a therapeutic goal.

To reduce the limit to $100 will force many elderly to pay greater out-of-pocket costs or to receive insufficient service, or no service at all.

The beneficiaries most affected will be those who live in rural areas or areas with limited access to the medical facilities or home health agencies for which Medicare reimbursement is liberal.

This proposed action is an example of ill-advised budget cuts which will have negligible impact on the Medicare budget, but a markeed negative impact on the beneficiary. We see no reason whatever to change the current law.

In summary, what has been proposed in the President's Fiscal Year 1983 federal budget is the antithesis of what we need:

We need reimbursement reform, such as a prospective system, to slow health care inflation and encourage providers to render care economically efficiently. We are offered no reform in the short run and a promise of questionable reform in the long run.

We need further development of non-institutional long-term care services. We are offered reduced benefits for home health care.

We need more physicians to accept Medicare's reimbursement levels and relieve us of increasong financial burdens. We are offered strategies which will reduce assignment and increase our costs.

We need proposals that will help to moderate health care costs. We are offered increased deductibles and higher levels of cost sharing.

We need help to meet our inordinate health care needs. We are offered the blame for the country's health care expense and we are punished for the perverse incentives of the Medicare reimbursement system.

We need what all Americans need but do not yet have: access to an affordable, comprehensive range of services that truly meets our needs. We have not been offered such access by the Reagan Administration, and the access we have is being whittled away.

Chairman **Jacobs**. Mr. Duncan?

Mr. **Duncan**. I have no particular question. I do want to thank the panel. You are always helpful when you come and visit with us. Your statements are excellent and we do want to thank you for your contribution. I know it will be quite helpful.

Chairman **Jacobs**. Mr. Anthony?

Mr. **Anthony**. Thank you, Mr. Chairman.

I would just like to say that although there are not that many people here to hear you personally, I think that your testimony being put in the record, is obviously going to strike a good chord.

I come from the State of Arkansas. We are second only to Florida in the percentage of senior citizens as compared to the population as a whole. I represent the Fourth District, southern Arkansas, and that particular district has the largest percentage of senior citizens in the State. So I can tell you that you have one friend on this committee that will be examining the proposals extremely closely, making sure that the administration can demonstrate fairness and equity on the record before those proposals gain the support of this particular committee member for reporting out of either the subcommittee or the full committee.

Failing that, I would be happy to participate with you on the House floor to try to bring some sanity to the budget process.

With that, I will just thank you for your contribution and tell you that I am willing to work with you.

Chairman JACOBS. I echo the sentiments expressed by Mr. Anthony. Both of you have made useful contributions in the past and this is no exception to the past. We are in your debt for that. Thank you very much.

Mr. Miller and Mr. McGarrah, the next panel. Mr. Miller representing the Service Employees International Union, AFL-CIO; and American Federation of State, County and Municipal Employees, represented by—that AFL-CIO also—represented by Mr. Robert M. McGarrah. I believe Mr. Miller is first on the list.

STATEMENT OF JOHN H. MILLER, PRESIDENT OF LOCAL 46, CHICAGO, ILL., SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, ACCOMPANIED BY CATHY SCHOEN, SPECIAL ASSISTANT TO THE INTERNATIONAL PRESIDENT

Mr. MILLER. Good morning, Mr. Chairman and subcommittee members. I would like to take this opportunity to introduce Cathy Schoen, special assistant to our international president, John Sweeney.

My name is John Miller and I am president of Service Employees Local 46 of Chicago, executive board member of the Service Employees International Union. I am testifying today on behalf of SEIU's 675,000 members nationwide, as well as Chicago hospital and public employees and my own local union.

Our testimony today addresses the disastrous effects the administration's 1983 budget medicare proposals would have on medicare's low-income beneficiaries and on inner city hospitals serving retired or disabled workers.

Last year few medicare beneficiaries were aware of the congressional proposals to increase hospital and physician deductibles. Deductible increases which took a minimum of $43 out of the pocket of every senior citizen in need of hospital care received virtually no immediate coverage or public debate until final reports sorting out what had happened.

The administration change in medicare as described in the 1983 budget request would repeat last year's attack on retired workers' health benefits and access to health care and threaten the survival of those hospitals with a commitment to serving elderly and low-income patients without regard to ability to pay.

Medicare by any reasonable standard of hospital care insurance is not a generous policy. This year, as a result of last year's decisions made in the heat of the budget process, elderly and disabled workers face a $260 hospital deductible each time they are hospitalized, plus a $75 annual deductible for medical services. Together these deductibles come to a minimum of $335 for any spell of hospitalization.

On top of this, beneficiaries must pay 20 percent of all medical service costs and all fees in excess of medicare payment rates. Medicare then charges $65 per day for hospital days 60 to 90 and $130 per day in excess of 90, with limits on total number of covered days per year. In addition, medicare long-term services and preventive health services are meager.

As a result of these combined gaps in medicare coverage, medicare paid only 44 percent of the total cost of health care for people 65 and older in 1977. Extensive congressional hearings in recent years have documented the growth of an infamous array of private supplementary policies collectively known as MediGap policies. The MediGap scandal is vivid testimony that retired workers need and are willing to pay for an expanded and improved health care coverage.

Instead, this administration proposes to shift still more costs onto the shoulders of the senior citizens and increase the risk that low income elderly individuals will go without necessary care. The administration would delay eligibility for coverage by 1 month, make any employer willing to hire workers 65 or older pay for the bulk of their health care by making medicare the second payer rather than the first as in current policy, raise premium charges for medical services, and for the first time charge medicare patients for home care following hospitalization.

Basically, these proposals all advocate shifting cost coverage from a medicare trust fund financed by payroll taxes and premiums to increased direct charges for patients. These higher costs would come at a time in worker lives when they are most likely to need health care and are least able to afford it. Such a regressive move would be particularly disastrous for low-income retired workers.

SEIU has many retired members who spent their working lives in low-wage service industries. For these low-income retired members, medicare is usually the only health insurance available to them upon retirement. Thus, senior citizens must pay for all the medicare deductibles in gaps and services out of their own meager pension and social security benefits. At today's health care prices, any illness quickly threatens bankruptcy.

Our members are also easy victims of fly by night health insurance policies claiming to fill in the gaps.

Two years ago SEIU put together a booklet describing medicare's gaps and what to look for in supplemental coverage. The booklet was an instant success. The demand far exceeded our expectations and we were quickly out of all copies. Since then we have been hard-pressed to put together another reprint, because the gaps keep increasing.

SEIU's members' experience with the barriers to care and inadequacy of medicare are not unusual. Various studies show that medicare deductibles and service gaps result in unequal access to care for minorities and other low income aged individuals.

Calls for expansion of specially focused home health care—yet the administration now proposes a 5 percent copayment on the first 100 visits following hospitalization. Given the pressing national need to get people out of hospitals as soon as medically possible into less expensive care settings, this proposal makes no sense.

The proposed decrease in medicare coverage would also hurt currently employed members of SEIU where SEIU has succeeded in negotiating for employer-supported health and welfare supplements for retired workers. The contributions for this coverage are based on expected gaps in medicare coverage. Increases in medicare deductibles, coinsurance and delays in coverage thus directly translate into higher health and welfare costs allocated to pay for retired workers.

As a result, the administration's attempt to cut medicare costs ends up shifting costs onto our employers and comes out of wages or benefits which otherwise would have gone to currently employed SEIU members.

Chairman JACOBS. Mr. Miller, we have just exceeded 6 minutes and 11 seconds. We will include the rest of your statement in the record, and perhaps your points can be developed through the questioning.

[The prepared statement follows:]

STATEMENT OF THE SERVICE EMPLOYEES INTERNATIONAL UNION

Good morning Mr. Chairman and Subcommittee members. My name is John Miller, President of SEIU Local 46 of Chicago and Executive Board member of the Service Employees International Union. I am testifying today on behalf of SEIU's 675,000 members nationwide as well as Chicago hospital and public employees of my own local union.

Medicare is vital to SEIU in two respects: it is the basic health insurance policy all our members depend on when they retire or if they should become disabled; and, as the primary source of insurance for senior and disabled workers, Medicare provides a major source of revenue to hospitals and home health agencies serving all SEIU members and providing jobs to some 150,000 of our members.

Our testimony today addresses the disastrous effect the Administration's 1983 Budget Medicare proposals would have on Medicare's low income beneficiaries and on inner-city hospitals serving retired or disabled workers.

Before detailing our concerns regarding the substance of the Administration's proposals, however, we would like to make some general comments on the use of the budget process to make substantive legislative decisions.

The current Medicare program and national health policy, whatever its flaws, is the product of years of legislative hearings, debate and public deliberation. Since enactment in 1965, subsequent proposals to expand, contract or otherwise alter Medicare eligibility, benefits or reimbursement were similarly open to public scrutiny and careful consideration.

The federal budget process makes informed public discussion of substantive Medicare changes impossible. As we witnessed last year, the speed of decision making and the multitude of program changes under consideration simultaneously hide what is happening to programs from the public eye.

For instance, last year few Medicare beneficiaries were aware of Congressional proposals to increase hospital and physician deductibles. Deductible increases which took a minimum of $43.00 out of the pocket of every senior citizen in need of hospital care received virtually no media coverage or public debate until final reports sorting out what happened.[1]

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[1] The Omnibus Reconciliation Act of 1981 raised the Part A deductible (hospital) from a scheduled $228.00 on January 1, 1982 to $256.00 per hospitalization. And increased the Part B deductible from $60.00 fo $75.00 per year. This comes to a minimum increase of $43.00 when a Medicare beneficiary needs hospital care and more if the beneficiary is hospitalized on several different occasions in one year.

Pushing these legislative changes through a massive budget cuts taxpayers and voters off from laws and programs of crucial importance to their lives.

For Medicare, a trust fund, the process is particularly inappropriate.

As you know, the bulk of Medicare is financed by a trust fund made up of a special health payroll tax. Dollars from workers' payroll tax payments go into the fund and are not available for other federal programs.

Thus, a dollar saved in Medicare hospital payments means a dollar surplus in the trust fund, and has nothing to do with deficits elsewhere in the federal budget. It is simply a fiction to claim on paper that a Medicare trust fund surplus somehow offsets general budget deficits.

Decisions which change benefits or eligibility for trust fund beneficiaries should be related either to the healthcare needs of the beneficiaries and general health of the trust fund and trust fund's finances, or to a broad, clearly stated health policy. And in both instances any changes should be subject to full public debate for a fully informed public discussion.

Retired workers have earned and paid for their Medicare program. Using the budget process as an excuse for substantive changes without adequate time for public hearings and without consideration of the health needs of retired workers, betrays workers' trust and undermines the entire federal legislative process.

THE ADMINISTRATION'S PROPOSED 1983 CHANGES IN MEDICARE

The Administration's changes in Medicare as described in the 1983 Budget request would repeat last year's attack on retired workers' health benefits and access to healthcare, and threaten the survival of those hospitals with a commitment to serving elderly and low income patients without a regard to ability to pay.

Impact on Medicare beneficiaries

Medicare by any reasonable standard of healthcare insurance is not a generous policy. This year, as a result of last year's decisions made in the heat of the budget process, elderly and disabled workers face a $256.00 hospital deductible each time they are hospitalized plus a $75.00 annual deductible for medical services. Together, these deductibles come to a minimum of $331.00 for any spell of hospitalization. On top of this, beneficiaries must pay 20 percent of all medical service costs and all fees in excess of Medicare payment rates. Medicare then charges $64.00 per day for hospital days 60 to 90, and $128.00 per day for days in excess of 90, with limits on total number of covered days per year. In addition, Medicare long-term care services and preventive health services are meager.

As a result of these combined gaps in Medicare coverage, Medicare paid only 44 percent of the total costs of healthcare for people 65 and older in 1977.[2] Extensive Congressional hearings in recent years have documented the growth of an infamous array of private supplementary policies—collectively known as "Medi-Gap" policies. The Medi-Gap scandal is vivid testimony that retired workers need and are willing to pay for expanded and improved healthcare coverage.

Instead, this Administration proposes to shift still more costs onto the shoulders of senior citizens, and increase the risk that low income elderly individuals will go without necessary care. The Administration would: delay eligibility for coverage by one month; make any employer willing to hire workers 65 or older pay for the bulk of their healthcare by making Medicare the second payer (rather than first as in current policy); raise premium charges for medical services; and for the first time, charge Medicare patients for home care following hospitalization.

Basically, these proposals all advocate shifting costs of coverage from a Medicare trust fund financed by payroll taxes and premiums to increased direct charges for patients. These higher costs would come at a time in workers' lives when they are most likely to need healthcare and are least able to afford it.

Such a regressive move would be particularly disastrous for low income retired workers. SEIU represents many retired members who spend their working lives in low-wage service industries. For these low income retired members, Medicare is usually the only health insurance available to them upon retirement. Thus, senior citizens must pay for all the Medicare deductibles and gaps in services out of their own meager pension and Social Security benefits. At today's healthcare prices, any illness quickly threatens bankruptcy. At risk of their own health, our Medicare-only retired members often put off seeking necessary early preventive or health maintenance services. The advanced stage of disease when these low income senior citizens are hospitalized ends up costing Medicare more than would have earlier use of services plus risks lives unnecessarily.

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[2] Charles R. Fisher, "Differences by Age Groups in Health Care Financing Review, Spring 1980," Volume 1 (4).

Our members are also easy victims of fly-by-night health insurance policies claiming to fill in the gaps. Two years ago SEIU put together a booklet describing Medicare's gaps and what to look for in supplemental coverage. The booklet was an instant success. The demand far exceeded our expectations and we were quickly out of all copies. Since then we have been hard pressed to put together a reprint because the gaps keep increasing.

SEIU's members' experience with the barriers to care and inadequacy of Medicare are not unusual. Various studies show that Medicare deductibles and service gaps result in unequal access to care for minorities and other low income aged individuals.[3]

In fact, most studies of Medicare over its seventeen year history have concluded with a need to expand and improve the health protection of the aged population by reducing deductibles and broadening long-term care coverage. The criticisms of overly generous policy were directed at reimbursement practices, especially for medical technology, not at benefits or eligibility.

Calls for expansion especially focused on home health care. Yet, the Administration now proposes a 5 percent copayment on the first 100 visits following hospitalization. Given the pressing national need to get people out of hospitals as soon as medically possible into less expensive care settings, this proposal makes no sense.

The proposed decrease in Medicare coverage would also hurt currently employed members of SEIU where SEIU has succeeded in negotiating for employer-supported health and welfare supplements for retired workers. The contributions for this coverage are based on expected gaps in Medicare coverage. Increases in medicare deductibles, coinsurance and delays in coverage thus directly translate into higher health and welfare costs allocated to pay for retired workers. As a result, the Administration's attempt to cut Medicare costs ends up shifting costs onto our employers and comes out of wages or benefits which otherwise would have gone to currently employed SEIU members.

With real wages down 9 percent in the past five years alone, the low-wage workers of the services industry cannot afford this cost shifting. Proportionately supplemental health insurance for retired workers takes a far bigger chunk out of SEIU incomes than it does out of supervisory wages and high-wage industries. The Medicare payroll tax and trust fund structure is a far more equitable way to finance the healthcare of the nation's senior citizens and to guarantee access to care than this regressive cost shifting.

The goal of breaking the link between access to healthcare and income has been the underlying rationale of the Medicare program and all healthcare reforms since the 1930s. Yet, now, the Administration proposes to roll back coverage and shift costs onto beneficiaries and private industry, returning us to the days when what you earned could well determine whether you lived or died.

Impact on hospitals

Many low income elderly and disabled Medicare beneficiaries already are unable to pay Medicare deductible and copayment costs or for uncovered services. The proposed increased costs and coverage reductions would significantly increase this inability to pay.

For those hospitals with a commitment to provide care without regard to ability to pay—public hospitals and many inter-city private hospitals—Medicare gaps in coverage for low income beneficiaries become patient bad debts. On top of these bad debts Medicare reimbursement for the costs of caring for beneficiaries has become increasingly restrictive without regard to a given facility's ability to make up for uncovered costs.

The Administration now proposes to add to this shortfall by reducing reimbursement by 2 percent in all hospitals.

This proposed across-the-board cut combined with increased costs would threaten the survival of literally hundreds of public and inner-city hospitals.

My own Chicago local represents healthcare workers at Cook County Hospital, a massive 1,363 bed facility—the primary source of care for serving low income families in the Chicago area. Cook's repeated financial crises are typical of hospitals attempting to serve all patients regardless of ability to pay.

In 1980 half of Cook's budget came from city and county tax assessments to pay for uninsured or inadequately insured patients. Only 9 percent came from privately insured patients or directly from patient payments. The remaining 41 percent of the budget came from Medicare and Medicaid. Due to the current recession and Medicaid cuts, workers at Cook are now reporting 200 to 300 additional uninsured patients per month over last year.[4] The proposed Medicare reductions could well topple what is already a fragile financial structure.

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[3] Karen Davis and Cathy Schoen, Medicare Chapter 4, pp. 104-112, Health and the War on Poverty: A Ten Year Appraisal," Brookings Institution, 1978.

Just two years ago members of our local working at Cook went three weeks without pay, waiting for emergency loans to come through to keep the hospital open. With all of Illinois and Chicago now suffering from the combined effects of a severe recession and drastic federal cuts in aid to states and cites, our local tax bases today will be even less able to cover the costs of increased deficits if Medicare coverage is slashed.

The financial stability of all of Chicago's other teaching and community hospitals is also at stake. Chicago's elderly and low income patients would not disappear if Cook were no longer open. Instead, Cook's 53,000 inpatient admissions and 600,000 outpatient visits would come to other area hospitals for care. Consequently, a multiple hospital financial disaster could well result if Medicare cuts destroyed the buffer of Cook County Hospital.

And a vital teaching facility would disappear as well. Cook, along with the rest of the nation's public general hospitals, now train some 40 percent of the nation's physicians. The need for equitable and rational Medicare cost and coverage policies extends to all hospitals serving the elderly.

As the accompanying chart of SEIU's San Francisco and Bay Area hospitals indicates, nonprofit private general hospitals derive anywhere from 32 to 60 percent of their revenue from Medicare. Those in the upper ranges, especially when Medicaid shrinking coverage is taken into account, clearly cannot afford any more cuts.

The common practice of shifting uncovered costs onto privately insured patients simply doesn't work well when private insurance pays a relatively small proportion of the bills.

TOWARD A RATIONAL MEDICARE POLICY

In closing, we at SEIU want to emphasize that while we agree with the Administration that the current rate of inflation in the healthcare industry hurts us all, we oppose the Administration's conclusion that the way to hold costs is to stop people from getting decent care.

We are also opposed to the notion that cost containment means controlling the costs of public programs only, regardless of how much of this cost is then shifted onto private insurance programs or patients.

A rational cost containment policy would protect access to care and cover all payers of care.

A rational healthcare policy would develop rate and budget controls necessary to deliver care efficiently with decent wages for the nation's healthcare workers.

SEIU urges the Committee to put aside all the Administration's proposals which shift costs onto Medicare beneficiaries and threaten providers committed to serve elderly and low income patients.

We also urge the Committee to stop the use of the budget and reconciliation process to make legislative decisions altering the Medicare programs. Legislative decisions of such national importance deserve to be given full public hearings and debate, rather than being hidden in a massive budget bill.

On behalf of all members of SEIU, I thank you for this opportunity to testify. SEIU staff will be happy to provide the Committee with any additional documentation or assistance necessary to support our statements.

We would also offer the Committee any support necessary in putting together a rational health policy—one which benefits patients and is concerned with the survival of essential national health facilities.

Thank you.

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[4] Linda Punch, "Public Hospitals Straining to Survive Federal Assault in Health Care Costs," *Modern Health Care*, December 1981.

SOURCES OF REVENUE FOR SEIU SAN FRANCISCO AND BAY AREA HOSPITALS

[Calendar year 1979]

	Percent			
	Total	Medicare	Medical	Other
Merrett	100	45	11	44
Peralta	100	51	7	42
Providence	100	58	15	27
Children's	100	10	53	47
Alta Bates	100	39	20	41
Herreck	100	52	25	23
Vespers	100	32	26	42
Ralph K. Davies	100	44	13	43
French	100	60	9	30
Childrens, (San Francisco)	100	27	16	57
Marshal Hale	100	54	10	36
Mary's Help	100	42	15	44
Mount Zion	100	41	24	35
Presbyterian	100	43	11	46
St. Francis	100	45	12	43
St. Luke's	100	38	30	32
St. Mary's	100	46	18	35

Source: California Health Facilities Survey.

Chairman Jacobs. Mr. McGarrah.

STATEMENT OF ROBERT M. McGARRAH, DIRECTOR, HEALTH AND INSTITUTIONS, AMERICAN FEDERATION OF STATE, COUNTY & MUNICIPAL EMPLOYEES, AFL-CIO, ON BEHALF OF GERALD W. McENTEE, INTERNATIONAL PRESIDENT, ACCOMPANIED BY CHRISTINE BURCH, LEGISLATIVE REPRESENTATIVE

Mr. McGarrah. Mr. Chairman, I am accompanied by Christine Burch, our legislative representative.

I have a statement from our international president, Gerald McEntee, which I would like to insert in the record.

Chairman Jacobs. Without objection.

Mr. McGarrah. After concocting the first triple digit budget deficit in history, it is hardly a surprise that President Reagan would ask you to bail him out with medicare cuts that will discriminate against the elderly and minorities and dump new costs on business, health insurance companies, labor and management.

The President asked you to discriminate against senior citizens who want to work for a living, by denying them first dollar medicare coverage. Even though they have paid their taxes for medicare protection, the President would make employers buy private insurance for these productive people. Simple economics means it will be cheaper for employers to force these people into retirement or deny them jobs in the first place.

Age discrimination is already so serious in this country it is prohibited by Federal law. So why create more incentives to violate the law? Why dump more Federal costs on business? As for public employers, for example, the Commonwealth of Pennsylvania tells us that their health benefit costs would immediately jump by more than $1½ million a year were this proposal to pass. The implication is clear: There will be more layoffs or more benefit cuts for all employees.

The centerpiece of the President's medicare cuts, a 2-percent reduction in daily hospital reimbursement, is, as you have heard, another way just to dump Federal costs and discriminate against both the elderly and hospitals that serve them. You are going to find that medicare beneficiaries will either have to pay these costs out of their pockets, suffer from inferior care, or hospitals will simply shift the cost to the rest of their patients.

Had the administration been more forthright, sir, I think that they just simply would have proposed an increase in the medicare payroll tax, for this 2-percent reduction will come out of all of our pockets anyway.

In Indianapolis, Mr. Chairman, officials at the Indiana University Hospital have asked us, when we wanted to talk to them about the medicare coverage: How much more blood can the Reagan administration take out of our budget? We simply cannot take these medicare cuts.

In Memphis, Tenn., we spoke with the administrator, William Jackson, of the City of Memphis Hospital, and he said they have already had to lay off 355 people, they have a deficit of over $7.5 million, and that these medicare cuts will wreak havoc on that hospital.

Many other big city public general hospitals are going to be hurt by these cuts. They average less than 24 percent of their total revenues from privately insured patients. The rest has to come from medicare, medicaid, and local tax subsidies and bad debts. These hospitals are the safety net of our health care system and they are going to be closed down if these cuts pass. There is simply no way they can withstand the impact.

In the midst of its zealous efforts to control spending for entitlements, the Reagan administration has actually authorized virtually unlimited hospital spending on antiunion activities, and here I refer to the fact that a little more than a year ago the Health Care Financing Administration prohibited hospitals from charging medicare for their expenses in responding to union organizing drives. Last month, however, Dr. Davis, who was just here this morning, reversed that policy and now medicare will pay for these so-called management consultants that are hired by hospitals and any other activities that are deemed legal under the National Labor Relations Act.

Cost estimates are scarce, Mr. Chairman, but HCFA staff and former leaders in the HCFA department have estimated that medicare spending for these management consultants will be in the millions of dollars a year. This is new spending at a time we are making severe cuts in the medicare program. What kind of equity is this, to pay for antiunion activities with Federal tax funds, while cutting billions of dollars from medicare beneficiaries?

This policy is unconscionable. Medicare funds were never intended to go for management's antiunion campaigns. In fact, this policy completely contradicts the National Labor Relations Act. Government is supposed to be a neutral party, not financing one side or the other, and at a time of cutbacks, we cannot tolerate this one. This ought to be cut out entirely.

There is a way to cut medicare costs, but it cannot work unless you account for two basic principles: First, consumers do not directly purchase health care themselves; and second, medicare is only an interrelated part of the whole health care spending system. Medicare cuts should come from an integrated health cost containment program covering all sources of health revenues. It should prospectively set budgets for hospitals and nursing homes, set negotiated fees schedules for doctors and other individual providers, and it ought to emphasize preventive care.

In the meantime, Mr. Chairman, we urge you to reject these medicare cuts as inequitable attempts to destroy health care for America's elderly. Shifting these costs to the old and minorities, business and labor, is simply inexcusable. Paying for antiunion activities is both fiscally and legally unconscionable. As a major part of the President's hopeless fiscal year 1983 budget, these medicare cuts should never see the light of day.

Thank you, sir.

[The prepared statement follows:]

STATEMENT OF GERALD W. MCENTEE, INTERNATIONAL PRESIDENT, AMERICAN FEDERATION OF STATE, COUNTY & MUNICIPAL EMPLOYEES

Mr. Chairman, members of the Subcommittee, I am Gerald W. McEntee, International President of the American Federation of State, County and Municipal Employees (AFSCME). We appreciate your invitation to present our views on President Reagan's proposed fiscal year 1983 budget cuts in the Medicare Program. AFSCME's more than one million active and retiree members are very concerned about the impact these irresponsible cuts on the elderly and the health care employees who serve them.

After concocting the first triple digit budget deficit in history, it's hardly a surprise that President Reagan would ask you to bail him out with Medicare cuts that both discriminate against the elderly and minorities, and dump new costs on business, health insurance companies, labor and management.

This $3 billion package of fiscal year 1983 cuts in Medicare comes on top of the cuts enacted last year, so the total cut for 1983 would be nearly $4 billion. Instead of an equitable plan to control all health care costs, President Reagan wants more inequitable cuts in Medicare.

He asks you to discriminate against senior citizens, who want to work for a living, by denying them first dollar Medicare coverage. Even though they've paid their taxes for Medicare protection, the President would make employers buy private insurance for these productive people. Simple economics means that it will be cheaper for employers to force these people into retirement or deny them jobs in the first place. Age discrimination is already so serious that it's prohibited by law, so why create more incentives to violate the law? Why dump more federal costs on business? As for public employers, for example, the Commonwealth of Pennsylvania tells us their health benefit costs would immediately jump by more than $1.5 million a year were this proposal to pass.[1] The implication: more layoffs or more benefit cuts for all employees.

The centerpiece of these Medicare cuts—a 2 percent reduction in daily hospital reimbursement—is just another way to dump federal costs and discriminate against both the elderly and the hospitals that serve them. Medicare beneficiaries will have to pay these new costs out of their own pockets, suffer from inferior care, or hospitals will simply shift the costs to the rest of their patients. Had it been more forthright, the Administration would have simply proposed an increase in the Medicare payroll tax. For this 2 percent reduction will inevitably come out of our pockets anyway.

Hospitals that serve large numbers of Medicare patients already take a loss on reimbursement. Why should they be penalized when other hospitals (particularly the for-profits) skim off the more affluent, privately insured patients? Why not reward efficient hospitals that serve the poor and the elderly instead of penalizing them?

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[1] Letter from Charles T. Sciotto, Director of Personnel, Commonwealth of Pennsylvania to Janet Kail, AFSCME Department of Research, Feb. 4, 1982.

Look at Cincinnati's Good Samaritan Hospital, for instance. Roger Weseli, its president, says that more than 40 percent of all patients are Medicare beneficiaries. Good Samaritan stands to lose nearly $1 million a year from these cuts.[2]

Officials at Indiana University Hospital, in Indianapolis, when asked about these Medicare cuts, asked us, "How much more blood can they [the Reagan Administration] take?"[3]

And in New York City, voluntary and municipal hospitals would lose more than $33.7 million next year if these Medicare cuts go through.[4]

Somebody inevitably will pay for these costs, and that somebody is everyone but the federal government. Either health insurance premiums rise, hospital employees take pay cuts and layoffs, or more hospitals completely close down—and these hospitals are the very institutions on which many Medicare beneficiaries depend for their sole source of hospital care.

Many are big city public general hospitals that today average less than 24 percent of their total revenues from privately insured patients.[5] Medicare, Medicaid, local tax subsidies and bad debts account for the rest. These hospitals are the "safety net" of our health care system. They are already on the brink of disaster. The President's Medicare proposals are merely one step toward their total demise.

The Administration's hacksaw approach toward health care in general and Medicare in particular, is best illustrated by its proposal to require beneficiaries to pay a 5-percent co-insurance charge for home health care services—saving, by federal standards, a meager $35 million a year.

Rather than recognize that home health care is cost-effective, that it keeps people out of hospitals and helps senior citizens remain as independent as possible; rather than recognize that people don't buy health care services the way they buy food (they get their health care on a doctor's orders—not their own), the Reagan Administration wants to deter unnecessary home health care by penalizing beneficiaries, not the people who ordered the unnecessary care in the first place.

This is utter nonsense.

Yet in the midst of its zealous efforts to control spending for entitlements, the Administration has actually authorized virtually unlimited hospital spending on anti-union activities.

Little more than a year ago, the Health Care Financing Administration (HCFA) prohibited hospitals from charging Medicare for their expense in responding to union organizing drives. Last month, however, HCFA reversed itself.[6] Medicare will now pay for these so-called management "consultants" and any other activities that are legal under the National Labor Relations Act.

Cost estimates are scarce, but HCFA staff estimate Medicare spending for these "management consultants" to be "in the millions" of dollars a year.

What kind of equity is this? Pay for anti-union activities with federal tax funds, while cutting billions for Medicare beneficiaries?

This policy is unconscionable. Medicare funds were never intended to go for management's anti-union campaign. In fact, this policy completely contradicts the National Labor Relations Act. Government is supposed to be a neutral party—not financing one side or the other.

Moreover, at a time of cutbacks, this is one spending program that must be cut out once and for all.

There is a way to cut Medicare costs, but it can't work unless it accounts for two basic principles: First, consumers don't directly purchase health care services themselves, and second, Medicare is only an interrelated part of all health care spending.

Consequently, cuts in Medicare should only come from an integrated health cost containment program covering all sources of health revenues. The program should prospectively set budgets for hospitals and nursing homes, and it should set negotiated fee schedules with doctors and other individual providers. It should reward efficient hospitals and doctors and emphasize preventive care. We will provide the Committee with a detailed proposal in less than a month.

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[2] Telephone interview between Roger Weseli, President of Good Samaritan Hospital, Cincinnati, Ohio, and Christina Burch, AFSCME, Feb. 26, 1982.

[3] Telephone interview between Christina Burch and Kenneth Bearslee, Associate Director, Financial Services, Indiana University Hospital, Mar. 1, 1982.

[4] Telephone interview between Dan Persons, special assistant for health services District Council 37, AFSCME, New York, N.Y., and Robert McGarrah, AFSCME, Feb. 26, 1982.

[5] Speech by Karen Davis, Ph.D., former Health and Human Services Deputy Assistant Secretary for Planning and Evaluation, to the National Association of Public General Hospitals, Jan. 17, 1982.

[6] Health Care Financing Administration, Provider Reimbursement Manual, sec. 2180.

In the meantime, we urge the Committee to reject these Medicare cuts as inequitable attempts to destroy health care for America's senior citizens. Shifting Medicare costs to the old, minorities, business and labor is simply inexcusable. Paying for anti-union activities is both fiscally and legally unconscionable. As a major part of the President's hopeless fiscal year 1983 budget, these Medicare cuts should never see the light of day.

Chairman JACOBS. Thank you, Mr. McGarrah, five minutes and 15 seconds.

Mr. Anthony?

Mr. ANTHONY. I have no questions, Mr. Chairman. I would like to thank the witnesses for appearing before the panel and for their constructive comments.

Chairman JACOBS. Mr. Duncan?

Mr. DUNCAN. I have no questions other than to thank the panel.

Chairman JACOBS. Mr. McGarrah, one question. How easy is it to distinguish between so-called informational activities by the hospital administration and antiunion activities?

Mr. MCGARRAH. Well, I think it is a little bit difficult under the current medicare reporting. The point is that there is no patient-care related activity in this informational business in a union-organizing drive. When hospitals tell you that it is patient-care related they are blowing smoke. You might as well finance the union itself out of medicare for its organizing drive. It is not easy to distinguish between "informational" and outright union-busting activities.

Ms. SCHOEN. We do have bill statements for some of these firms that were called in only because a union was there and then disappeared after the union left, that are costing anywhere from $250,000 to $300,000 a year for these consulting fees. It is a very expensive practice.

Chairman JACOBS. Why would this administration want to finance antiunion activity?

Mr. MCGARRAH. Well, Mr. Chairman, the president of our union has said that this administration and the President is slightly antiunion. I think that is the only rationale.

I think this is wasteful. I think this is irresponsible, when we are trying to cut the medicare budget.

Chairman JACOBS. But I read in the paper this administration is a strong supporter of unions in Poland.

Mr. MCGARRAH. In Poland. Well, it may be the case in Poland, but not here.

Chairman JACOBS. We thank you for your contribution to the record, gentlemen.

The next panel consists of the Health Insurance Association of America, Mr. Philip Briggs, executive vice president, Metropolitan Life Insurance Co.; and Blue Cross and Blue Shield Associations, represented by Mr. Cardwell. Everybody knows that is James B.

So Mr. Briggs, if you would like to proceed, you could try your hand at winning the prize.

STATEMENT OF PHILIP BRIGGS, EXECUTIVE VICE PRESIDENT, METROPOLITAN LIFE INSURANCE CO., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AND THE AMERICAN COUNCIL OF LIFE INSURANCE

Mr. **Briggs**. My name is Philip Briggs. I am executive vice president, Metropolitan Life. I appear here today on behalf of the Health Insurance Association of America and I am joined in this statement by the American Council of Life Insurance.

Mr. Chairman, the HIAA is completely supportive of the administration's goal of controlling inflation. No industry is hurt more by inflation than the insurance industry. Our support for cost containment measures in the health field has been second to none.

However, the HIAA must oppose the 2-percent across-the-board reduction in Federal reimbursement to hospitals for the care of medicare patients, as well as any other arbitrary cut in payments to providers that do not in reality represent true program cost reductions, but are merely the shifting of present costs to other patients.

The 2-percent solution shows in stark reality what has been going on for years: a continuing ratcheting down of medicare reimbursements, using one excuse after another to redefine reasonable costs. That has always been an excuse, a reason, but the result has always been the same: another ratchet down.

The cost of medical care is too high. It is too high for all of us. It is simply not fair for the Government to solve its problem by fiat and leave the rest of us to pick up the pieces. It has a responsibility to look at the results of its actions on the rest of the system.

The 2-percent solution is not being a prudent purchaser. It is not picking and choosing from whom it will buy, shopping judiciously for price and quality. It is using naked economic power that comes from the hospitals' dependence on Government patients and the full power of Government to arbitrarily reduce its expenses across the board, take it or leave it.

Nor is the proposal cost containment, as many would have us believe. It is a step toward cost escalation and has a direct impact on not only hospitals but employers and private paying patients, who ultimately must bear the burden of spiraling health care costs. As a practical matter, the hospitals, if it is enacted, have no choice but to take it.

Those hospitals which are prosperous and have plenty of patients to shift the cost to, that may be an excellent solution, preferable perhaps to rule changes that increase administrative costs and redtape with the same result. But the 2-percent solution hits all hospitals across the board, efficient and inefficient alike, lean as well as fat. The result must in fact be inordinately hard on those hospitals with a high proportion of medicare and medicaid patients or a large proportion of charity cases or bad debts.

There is a broad agreement that the status quo is unacceptable. What are the solutions? In January of this year the HIA joined five other organizations, including the AFL–CIO, the Business Roundtable, Blue Cross-Blue Shield, the American Hospital Association, and the American Medical Association in a joint statement calling for the development of health care coalitions on the State and local level. It is an important means of restraining costs and improving the quality and access to care.

Other steps toward a solution have already been taken in Maryland, New Jersey, and Illinois. Enabling legislation in these States give hospital rate-setting authorities jurisdiction over rates paid by all private sector patients, and the Federal Government pays comparable rates for medicare patients under section 222 of the social security amendments of 1972. This section allows the Secretary to waive the usual reimbursement regulations in order to experiment with prospective payment systems.

The Maryland Health Services Cost Review Commission figures show a total savings of $86.5 million for the Federal Government under the medicare-medicaid programs for the 3 years of 1978, 1979, and 1980.

The Congress took another step forward last year when it directed the Department of Health and Human Services, in Public Law 97-35, to devise a system of prospective reimbursement for hospitals suitable for both medicare and medicaid. We strongly support the development of a prospective reimbursement system that is equitable to all payers and provides hospitals with rewards, not penalties, for more efficient behavior.

Thank you, sir.

[The prepared statement follows:]

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AND THE AMERICAN COUNCIL OF LIFE INSURANCE

My name is Philip Briggs. I am Executive Vice President of the Metropolitan Life Insurance Company. I appear today on behalf of the Health Insurance Association of America and am joined in this statement by the American Council of Life Insurance.

Any enterprise, if it is to survive, must recover the costs of producing goods and services. Both fixed and variable costs must ultimately be reflected in the prices consumers pay. If one segment of a business suffers losses, then these losses must be offset by gains elsewhere. Otherwise, the entire enterprise will fail.

Hospitals, physicians, and nursing homes are no exception to this rule. Federal and state governments unfairly restrict their payments to health care providers, paying only part of the hospital costs of Medicare and Medicaid patients. When the government refuses to pay its full share, everyone else must pay more. Costs not covered by Medicare and Medicaid for their patients must, therefore, be recovered from private patients. It is, in effect, a hidden tax on sickness, levied on a hospital's non-government patients to pay those hospital expenses not paid by Medicare.

Despite widespread concern about rising health care costs, little attention has been focused until recently on the practice of cost-shifting from the public to the private sector.

This is how it works. Under the payment formulas established by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services, certain hospital costs are not recognized. These include:

The bad debt and charity costs incurred in treating patients who do not pay their bills.

Certain equity capital requirements necessary for replacement and addition of facilities and equipment.

Certain hospital educational and research costs.

At the same time, the government has progressively tightened its regulations for determining reimbursable costs. Section 1816 of the Social Security Act states that "reasonable cost shall be determined by regulation which may provide for the establishment of limits on the direct or indirect overall incurred costs * * * to be recognized as reasonable." These limits have been repeatedly lowered. As a result, the "hospital payment differential," that is, the difference between what Medicare and Medicaid choose to pay and what private sector patients pay, continues to grow year by year.

Mr. Chairman, the Congressional Budget Office last year stated that Medicare pays, on the average, 16 percent less than the average non-government patient. This, as troublesome as it is, of course, understates the problem in many areas. I can only call your attention to the man who drowned in the river which was only one foot deep—on the average.

We believe strongly that, if a hospital has two patients, side by side, receiving the same care, in identical circumstances, it should receive the same payment regardless of who the payor is.

The situation is growing worse, not better. From 1975 to 1979, the differential rose from $12 to $41 per adjusted patient day, an increase of 242 percent. Based on this rate of growth, the difference will rise to $99 per adjusted patient day in 1983.

Stated another way, on an average daily basis in 1979, Medicare payments were $198 while private patients were charged an estimated $239 for the same service. Overall, the shortfall in government payments increased from $1.1 billion in 1975 to $3 billion in 1979. Moreover, the Health Insurance Association of America (HIAA) now estimates that the 1981 shortfall will exceed $4.8 billion. This gap will surely widen if Congress approves a 2 percent across-the-board reduction in Federal reimbursements to hospitals for Medicare patients.

Faced with this shortfall in revenue, hospitals have two choices. They may draw upon available hospital reserves, if any, to make up the deficit or they must overcharge patients who are not under government programs. Most hospitals adopt the second option to preserve their fiscal integrity. Thus, government reimbursement practices lead directly to differentials in payment between government and private patients. The end result of lower Medicare/Medicaid payments is cost-shifting to private patients, not cost containment.

These growing shortfalls are hurting hospitals, hampering employer efforts to contain health care costs, and inhibiting the potential for further developing competition in the health care system.

Many inner-city and rural hospitals with a high proportion of Medicare/Medicaid-cost-reimbursement patients have extraordinary shortfalls and differentials. At these hospitals, there are fewer patients who pay full charges, and the hospitals are unable to shift their losses to private patients. Consequently, it is not surprising that some of these institutions are already in financial distress, and the 2 percent reduction could be the final blow. One hospital administrator expressed the dilemma to us this way:

"Today, at Greater Southeast Community Hospital (in Washington, D.C.), a patient who is hospitalized for five days and who undergoes surgery will incur the same charges or bills—but the hospital will be paid the following: D.C. Medicaid, $2,401; commercial insurance, $3,184; Blue Cross, $2,881; Maryland Medicaid, $2,675; and Medicare, $2,520."

"That's a 25 percent spread on one bill. This inequity punishes hospitals and patients alike, particularly middle-class patients who must subsidize the below-cost reimbursement of Medicare and Medicaid." (Barry A. Passett, President of the Foundation which oversees Community Hospital in Washington, D.C.)

Arbitrary reductions in government reimbursements do not encourage hospitals to economize to meet lowered payment schedules. Instead, once hospitals begin shifting costs to the private sector, increasing charges becomes a logical and routine response to government reimbursement limitations.

Clearly, the severity of the problem restricts competition in the health care marketplace. Stated very simply, private payors cannot compete with Medicare (for example, through a voucher system) when the government buys at less than full cost 40 percent of the nation's total hospital services. Hospitals cannot compete on the basis of price when their payments are arbitrarily reduced for a large percentage of their patients. Furthermore, in certain areas of the country, commercial insurers are virtually unable to compete with Blue Cross plans because of Blue Cross contractual arrangements to pay hospitals less than they must charge other private patients. In those areas where the Federal shortfall is not spread evenly across the non-government patients, the problem is, of course, exacerbated.

Mr. Chairman, the designers of Medicare believed at the outset that by paying only for the actual cost of treating government-program patients (i.e., the "cost payment" method), hospital reimbursement would be effectively controlled. It soon became apparent that the cost-payment method, which provided for retrospective payment of all recognized costs, did not result in the desired accountability.

On the contrary, because the costs were adjusted by being paid retrospectively, hospitals were not at risk financially and, therefore, had little incentive to hold down costs. What reward did a hospital administrator get who worked hard and did, in fact, lower his costs? Less money. A reduced cash flow. Is it any wonder that

Medicare/Medicaid expenditures began to outstrip general inflation in the economy?

What of solutions? The Congress made a beginning last year when it directed the Department of Health and Human Services, in Public Law 97-35, to devise a system of prospective reimbursement for hospitals suitable for both Medicare and Medicaid. We strongly support the development of a prospective reimbursement system that is equitable to all payors and provides hospitals with rewards, not penalties, for more efficient behavior.

Other steps toward a solution have already been taken in a few states. Examples are Maryland, New Jersey, and Illinois. Enabling legislation in these states gives hospital rate-setting authorities jurisdiction over rates paid by all private sector patients.

In addition, these authorities have obtained approval from the Federal and state governments to establish comparable rates for Medicare/Medicaid payments. Such approval was obtained under Section 222 of the Social Security Amendments of 1972. This section allows the Secretary to waive the usual reimbursement regulations in order to experiment with prospective payment systems.

By participating in the waiver system, Medicare and Medicaid agree to reimburse for certain services for which they would not otherwise pay. In effect, therefore, they would pay on the same basis as private insurers.

On the surface, such concessions would appear to be more costly. Medicare and Medicaid, however, are willing to participate in prospective payment systems under the waiver authority because these systems provide positive incentives for reducing overall hospital cost escalation and thereby generate cost savings.

These incentives result because this system prospectively approves a hospital's budget, thereby determining in advance needed hospital revenues which will form the basis of payment by all patients.

In this way, hospitals are encouraged to achieve savings by increasing their operating efficiency. By reducing operating below approved revenue levels, a hospital can produce a surplus that can be used at its discretion. It can be applied to new programs, services, or simply contributed to the hospital's reserves to help assure financial stability.

It should be pointed out that a waiver includes inside limits on the government's liability. Operating with a Medicare/Medicaid waiver, Maryland has achieved both equity among payors and government payments that are at least as low as they would have been in the absence of the program.

In the three years of 1978, 1979, and 1980, the Medicare and Medicaid program saved a total of $86.5 million in Maryland compared to what total expenditures would have been if that state's program did not exist.

Mr. Chairman, the HIAA is completely supportive of the Administration's goal of controlling inflation. No industry is hurt more by inflation than the insurance industry. Our support for cost containment measures in the health field has been second to none. Most recently, in January of this year, the HIAA joined five other national organizations, including the AFL-CIO, the Business Roundtable, Blue Cross-Blue Shield, the American Hospital Association, and the American Medical Association, in a joint statement calling for the development of health care coalitions on the State and local level as an important means of restraining costs and improving the quality and access to care. However, it must be clear from the foregoing that the HIAA must oppose the 2 percent across-the-board reduction in Federal reimbursements to hospitals for the care of Medicare patients, as well as any other arbitrary cuts in payments to providers which do not in reality represent true program cost reductions but are merely the shifting of present costs to other patients.

The 2 percent solution shows in stark reality what has been going on for years, a continuing ratcheting down of Medicare reimbursement using one excuse after another to re-define "reasonable cost." There has always been an excuse, a reason, but the result has always been the same—another ratchet down.

If the cost of medical care is too high, it is too high for all of us. It is simply not fair for the Government to solve its problem by fiat and leave the rest of us to pick up the pieces. It has a responsibility to look at the results of its actions on the rest of the system.

The "2 percent solution" is not being a "prudent purchaser." It is not picking and choosing from whom it will buy, shopping judiciously for price and quality. It is using naked economic power that comes from the hospital's dependence on government patients and the full power of government to arbitrarily reduce its expenses across the board, take it or leave it.

Nor is the proposal cost containment, as many would have us believe. It is a step toward cost escalation and has a direct impact on not only hospitals, but employers and private-paying patients, who ultimately must bear the burden of spiraling health care costs.

And, as a practical matter, the hospitals, if it is enacted, have no choice but to take it. To those hospitals which are prosperous, and have plenty of charge patients to shift the cost to, it may be an excellent solution, preferable to razzle-dazzle rule changes that increase administrative costs and red tape with the same result. But the 2 percent solution hits all hospitals across the board, efficient and inefficient alike, lean as well as fat. The result must, in fact, be inordinately hard on those hospitals with a high proportion of Medicare and Medicaid patients, or a large proportion of charity cases or bad debts.

There are, on the other hand, practical steps to reduce program costs which we do not oppose. We would support bringing all Federal employees under the Medicare system, since many qualify for it already.

We do not oppose Medicare secondary to employee group insurance for workers over age 65, nor do we see any practical problems with delaying the initial elegibility date for Medicare beneficiaries.

There is a broad agreement that the status quo is unacceptable. Indeed, research reveals a high degree of public concern with the problem. Though there may be difficulties in implementing corrective action—and even a lack of unanimity on the best option—the future stability of the health care system demands that the problems caused by cost-shifting be recognized, addressed and resolved in the public interest.

Mr. Chairman, on the subject of containing the rising cost of Medicare, there is another issue of vital importance—the Medicare competitive contracting proposal and the overall budget crisis facing the intermediaries and carriers.

You are undoubtedly aware that total Medicare payments to hospitals, doctors, and other providers will come close to $50 billion in 1982. Medicare payouts have increased by more than 20 percent each year since fiscal year 1980 and threaten the entire Federal budget.

I mention this because private insurance companies not only have the responsibility for paying claims efficiently, but also must assure that claims on the Trust Funds are legitimate, appropriate, and reasonable. The intermediaries and carriers have performed this function on a no-profit, no-loss basis since this partnership for Medicare Administration was formed in 1966. This method of joint administration which costs only 1.7 percent of the whole program, has been a major success and serves as a model for how complex public programs can be managed.

In this context, the competitive contracting proposal sends us another signal that too many people are focusing on the 1.7 percent rather than on the $50 billion. In 1972 it cost 3.4 percent of the total program for administration. Today that figure has been cut in half. Our record for consistently lowering the cost of claims administration despite inflation and increasing workloads is clear.

However, the budgets for Medicare Contractors for fiscal years 1981, 1982, and now proposed for 1983 are so seriously under-funded that they jeopardize the partnership built so carefully over 15 years. The tail is wagging the dog. Budget cuts have forced us to give up the trained professional personnel we need to adequately supervise the $50 billion in program payouts. If the Medicare carriers and intermediaries are to continue to do the job expected of them, they must be adequately funded. To do otherwise is penny wise and pound foolish on an unprecedented scale.

Thank you.

Chairman JACOBS. Thank you, sir; 4 minutes, 15 seconds. Mr. Cardwell.

STATEMENT OF JAMES B. CARDWELL, EXECUTIVE VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATIONS

Mr. CARDWELL. Mr. Chairman, I thank you very much for the chance to be here today.

As someone who has spent a good deal of his work life on the other side of this issue, I have a great appreciation for the dilemma that the Congress faces, for that matter the Government faces. I do not think any of us can quarrel with the need to bring the Federal budget into better balance. But I must say to the committee, from both my prior experience and as a spokesman for the Blue Cross and Blue Shield Associations, I do not think that, taken together, the proposals that are now before this committee in terms of reducing 1983 care expenditures will achieve their intended result.

And I would have to also say that certain of the proposals in my judgment, using the 2-percent hospital reimbursement limitation as an example, will also work against the system as a whole.

Our recommendation to you today is really not that different from recommendations made by others. We think that the subject has reached the point where the Congress—and I would like to urge the administration to take the same point of view—needs to step back and take a look at what you want medicare to be. Examine it in terms of the proposals to cut the budget, in terms of what might happen to the integrity of the program itself, how the cuts affect eligibility, benefits, and in particular beneficiary out-of-pocket costs; examine their impact on the rest of the delivery system in terms of whether they will truly influence cost containment and whether they are consistent with the original principle of medicare—that Government will pay reimbursement for its share of the cost of care for its clients.

The kinds of options that are before you today are really not that different from others in the past, except that they appear now to be more dramatic, because we probably are very close now to the bottom of the barrel of the kinds of actions that we can take to patch and pull and push medicare expenses.

If we examine the actions of the past, they have not achieved their result. We have not constrained the rising cost of care to the Government. We have not contained the basic cost of delivering care. We have not established new systems of incentives to influence the behavior of the overall system. And it is the behavior of the overall system that must be addressed if you are going to solve the basic problem that faces the Government and faces all other buyers of care.

These kinds of actions work against long-term solutions. Let us take a quick look at some examples on the list before you. There are some that redefine eligibility. There are others that clearly shift previously covered costs to employers. There are others that shift costs to beneficiaries. And you are familiar with the list and I will not go into it.

What we really have is a Government that says, we do not like the price so we will not pay it. Other buyers who do not like the price do not buy. But with its power and leverage, the Government takes the position, that is not for us; we will not only set our price, we will continue to use the service. And this is not a responsible position for the U.S. Government to take when it deals with the public at large, and these kinds of cuts certainly represent that sort of situation.

Now, what do we suggest? If you examine the whole panoply of ideas and suggestions that have been made through the years, and if you examine those that are before you today, in our judgment there are only two practical things that you could do today. That does not mean that there are not other things that could be worked out in the long run.

We must move out ahead on prospective reimbursement options. We keep talking about it, but we do not do it. And we can take some practical new steps to improve utilization review, both at the provider level and certainly among the fiscal agents. Both of those actions are practical and we would urge them for this point in time.

On the point of improved utilization review, Dr. Davis today talked about that as an area that would be emphasized in their relationship with the medicare contractors. I would urge this committee to examine the fiscal budget for 1983 for medicare administration. I think you may find that the funds for that particular activity are being obtained at the expense of the basic contracting and administrative activity, with new risk that you will pay higher reimbursement cost in the long run.

That budget does not normally come before this committee, but I think it would serve you well to examine it.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATIONS

Mr. Chairman and members of the committee, we appreciate the opportunity to appear today. Our purpose is to offer the experience and perspective of the Blue Cross and Blue Shield organization in your deliberations of the 1983 budget for medicare.

There can be no doubt of either the difficulty or the importance of the task before you. In our opinion the decisions to be made have important consequences not just for Medicare and the people served by these programs, but also for the basic fabric and integrity of the private health care delivery and financing systems.

The dilemma of increasing utilization and rising costs is clearly not medicare's alone. It is faced by all who depend on our health care system and all who have a role in its financial integrity--ranging from employers, unions and insurers to individual citizens who buy insurance or who self-insure.

Mr. Chairman, we understand and share the cause of constraining the Federal budget. One way or another, it must be brought into better balance. But we feel compelled to say that we do not believe that, taken together, the expenditure reductions proposed by the administration for medicare can achieve their expected results. Of greater concern is our belief that some of them, such as the 2 percent hospital reimbursement limit, will work against both their own purpose and the long-term interest of the overall health care system.

We should pause to point out, Mr. Chairman, that we recognize the importance of budget actions aimed at more efficient management of the medicare program. But, we believe that the process must be carried out within a public policy framework that sets the parameters for the budget. We do not see such a policy framework as now being in place for medicare.

Our recommendation at this time is that the proposals now before you be assessed in the broader context of:

First, their effect on the basic integrity of medicare: how they affect eligibility, benefits and beneficiary out-of-pocket costs.

Second, their impact on the rest of the delivery system in terms of whether they will truly influence cost containment, and whether they are inconsistent with the principle of the Government paying its fair share.

To understand why we make this suggestion, it is important to examine what has happened so far and what is likely to happen if the 1983 budget actions are not evaluated within this broader context.

First, limits and caps imposed through annual budget constraints and selective ad hoc legislative and regulatory actions of the past have not fulfilled either their short or long-term objectives. They have not prevented increased utilization or increases in basic costs. There is no question but that medicare has had a positive influence on provider efficiency, but this has come from the thrust of the program itself and not through budget caps and limits—although such limits were originally adopted in the name of improved efficiency.

The limitations have not always been consistent or objective in either their design or their effect. They have shifted back and forth in their effect on benefits, entitlements, and, in some cases, eligibility.

At times, the caps and limitations have resulted in severe swings in beneficiary out-of-pocket costs. For example, after years of deferring the medicare deductibles, the 1982 budget included an abrupt increase—an increase which has affected not just the out-of-pocket expenses of beneficiaries, but also their medigap premiums. This confuses and frustrates beneficiaries, and lays a special burden on Blue Cross and Blue Shield plans to seek commensurate rate increases.

Perhaps more important than all of their other characteristics, these actions have not seemed to follow any consistent principle of medicare reimbursement—medicare paying its fair share of the true cost of care.

The list could go on. But, what is important is to be aware of the uneven pattern of these actions and their affect on other parties at interest.

Many of the 1983 proposals represent a continuation of this pattern. We clearly are now at a point where the integrity of the program itself and the interests of the beneficiaries it serves are at risk. For example, the 1983 cuts would: Redefine eligibility for medicare beneficiaries (from the first of the month a person reaches 65 to the first of the next month). The question is whether this change would be consistent with overall policy on eligibility; shift previously covered costs to employers of the elderly at a time when the Social Security system suggests longer attachment to the work force. (Modified, secondary coverage for the working aged); establish a 5-percent coinsurance for home health benefits—a change in coverage; delay updating physician fee screens. This will mean fewer assignments and invites cost transfers to patients; finally, the 1983 budget introduces the 2-percent reduction in medicare reimbursement to hospitals. This is an example of the government asserting its leverage—to not pay full cost on grounds that costs are too high.

On this latter point, we believe the Government should bargain with providers to limit its payment to only those costs directly related to their clients. But, the 2-percent cut and others in the past do not fit this concept. Instead, they are one-sided actions that leave the consequences to others. They are also another example of unilateral actions taken without the benefit of a basic policy framework against which to judge the Government's financing and payment practices.

We believe such a framework is critical for both the 1983 budget and legislative processes and for the future development of the program. Our concept of such a framework is as follows: First, it should include a principle of balanced reimbursement of all appropriate costs traceable to the medicare beneficiary population; and second, clear-cut and updated concepts of eligibility and coverage, both short and long term.

Once a public policy is agreed to for these two areas, Congress can then move to policy changes directed toward true cost containment. Among the actions that we think hold promise in this regard are: Prospective reimbursement options that recognize the utilization characteristics of different classes or users; and new and improved approaches to utilization review, beginning with new arrangements for utilization review by providers and medicare fiscal agents.

These two areas have been discussed and debated before. But, they still represent the best opportunities we have to change the behavior of the marketplace.

Chairman JACOBS. Thank you, Mr. Cardwell. Five minutes, 44 seconds.

Mr. Anthony?

Mr. ANTHONY. Thank you, Mr. Chairman.

Mr. Briggs, you said that the 2-percent solution is shifting costs to someone else. The administration witness, Dr. Davis, said that there are enough sloppy management initiative savings that can be made. Could you explain the difference in your two viewpoints?

Mr. BRIGGS. Well, I am afraid, Mr. Anthony, that prior experience with this ratcheting down of medicare costs has demonstrated an increasing cost shift. I think we have been able to document that that cost shifting has already taken place to a considerable degree, and in fact for 1981 it has been estimated that cost shifting from medicare to the private sector amounted to $4.8 billion.

We are very concerned that this trend will continue and that the amount will be much larger as a result of this proposal.

Mr. ANTHONY. You also made a comment that you also thought that 2 percent across-the-board was structurally unfair—structurally unfair in that efficient hospitals are treated the same as the sloppiest, most cost inefficiently run hospitals.

Mr. Briggs. Well, I am afraid any of these arbitrary measures will tend to do that, yes. That is what we implied and what we meant.

Mr. Anthony. Well, did you have an opportunity—did the Health Insurance Association of America and the American Council of Life Insurance have an opportunity to give this input to OMB before this budget document was put together?

Mr. Briggs. We have discussed this, sir, yes, with all the people that we are in contact with on a regular basis.

Mr. Anthony. So they have heard your rationale and they have discarded it?

Mr. Briggs. Yes, they have.

Mr. Anthony. Mr. Cardwell, you have heard Mr. Briggs testify about the cost sharing. And let me say that his opinion seems to be as strongly held as the administration's position is strongly held. I wonder what your views are on the cost shifting from the public sector to the private sector.

Mr. Cardwell. Well, I believe that past experience with what Mr. Briggs described as earlier ratchets certainly shows that some cost shifting has occurred. I would expect that some further cost shifting would follow this particular proposal.

I find fault with it, though, for other reasons as well. The first is that it does not follow a basic principle of paying for services purchased, if you do not like the price do not make the purchase. And what the Government is saying is that, we think hospital costs are much too high and that, as a large buyer, we are going to arbitrarily draw a line and say that we will not pay the price.

Now, we happen to believe in Blue Cross and Blue Shield that it is perfectly appropriate for the Government to bargain for the best price that it can obtain, but once it reaches agreement on the price it should pay it, just as all other buyers pay. If we really believe in the marketplace, which the Government certainly contends that it believes in, this is not marketplace behavior at all. It is arbitrary leverage exercised by the Government through the power and force of law and regulations.

I find that to be a very fundamental flaw in this idea, as well as some of the other ideas that are now before you.

Mr. Anthony. Did you have an opportunity, representing Blue Cross and Blue Shield, to make these views known to OMB prior to their final budget decision and a document being printed and submitted to the Congress?

Mr. Cardwell. We certainly were not privy to specific proposals that were considered by either OMB or the Health and Human Services Department. On the other hand I would have to say that we were consulted in different ways and at different times by analysts in the Office of Management and Budget concerning how the system works. The impact of cost transferring, the concepts of full payment, the concepts of insurance, and all those things have been discussed many times.

But we certainly were not asked to comment on these proposals per se.

Mr. Anthony. In specifics?

Mr. Cardwell. That is correct.

Mr. ANTHONY. Mr. Chairman, if you will indulge me, just one last question.

I have been receiving some telephone calls in recent days from senior citizens concerned about whether or not they need to go buy medigap insurance. They know what happened in the Reconciliation Act of 1981. They see the proposed budget cuts in 1983. The question simply has been asked of me, do you advise me to go out and buy some supplementary health insurance, because I would like to be fully covered.

I would just like to know what your view is? Who sells that stuff? I would like to know what your position is, what Blue Cross-Blue Shield's position is as far as what effect the increased coinsurance and deductible amounts for medicare beneficiaries through the budget Reconciliation Act has done, and what do you see coming in 1982 and 1983?

Mr. CARDWELL. It is a good question. I appreciate the opportunity to comment on it, because it is something that we find troublesome as of this moment. We believe that, first of all, that the medicare population at large does not understand that the Government changed the medicare deductibles in 1981. What they really have run into first is the fact that their premiums for medigap coverage are going up, and they tend to identify that act with the carrier and not with the Government.

Those who are better informed as of the moment might say, well, I can see the Government is on a trend now to increase deductibles. And many people obviously will decide that they want to protect themselves by buying insurance. And both the commercial insurers and the Blue Cross and Blue Shield plans offer such insurance.

In our case, though, that is producing a problem. The premiums cannot always catch up with the rising costs, and in our case we are also subject to regulation within many of the States, and the State regulators will not increase the premiums commensurate with the increased coverage cost. So we find ourselves in a bit of a bind.

But this is a new market for private insurers, there is no question about it. If the Government continues to push the cost of various forms of coinsurance to medicare beneficiaries, they are creating a larger medigap insurance market that the insurance industry will move into.

Mr. ANTHONY. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Duncan?

Mr. DUNCAN. I have no questions. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Briggs, the administration refers to a new private sector coalition effort to reduce the cost of the medicare program in 1983. They have a lot of faith in that. Do you?

Mr. BRIGGS. Well, sir, I am not sure whether that has been demonstrated or that they have found a way of doing it yet. I am hopeful by getting the various key parties together, whether they be the hospitals, the doctors and the insurers, we can get perhaps a better arrangement worked out. But we have not been able to do it yet. We have been working at it for some time.

Chairman JACOBS. Probably during the general history of the world, was it not George Bernard Shaw who said: "To do good is noble; to advise others to do good is also noble, and much less trouble." But I suppose we can always hope for redemption.

I thank the panel and the committee thanks the panel for its contribution, which is useful.

The next panel: Mr. John McMahon and Mr. Michael Bromberg, representing respectively the American Hospital Association and the Federation of American Hospitals.

Four minutes, 6 seconds, is the champion of the day so far. Mr. McMahon, please proceed.

STATEMENT OF JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. McMahon. Thank you, Mr. Chairman. I am Alex McMahon, president, American Hospital Association, and I appreciate the opportunity to appear before this panel. You have my testimony for the record. I would like to make a couple of brief points.

First, hospitals are and have been concerned with the rate of increase in health care costs and the problems that are attendant to those rates of increase, and I have commented on that problem on pages 3 and 4 of the testimony. It is why we got involved in the voluntary effort, Mr. Chairman and members of the committee, and why we are now in full support of these coalitions, which I do believe have much to offer.

The voluntary effort did not work, Mr. Chairman, in its later years because the incentives in the whole health area are expansionist. I have testified and made that point before you, sir, on consumer choice, and I have commented with respect to prospective payment in the same fashion.

Hospitals have suffered, as I noted in the testimony, from the present reimbursement system. Costs are not accepted, limits are put on reimbursement and unrecognized costs are indeed shifted to other parties. Costs are not reduced, nor is there any incentive to reduce them under cost-based reimbursement, because if they are reduced, Mr. Chairman, payment is reduced as well.

I do want to comment on that 2-percent reduction that Dr. Davis and the administration have suggested. It is just more of the same, and I pointed out the problems on pages 4 and 5.

Mr. Anthony, Dr. Davis responding to your question, said it will lead to prudent management. Absolutely not, sir. With all the prudent management in the world, you are still penalized another 2 percent. That just is not the way to go about it.

Two percent is a reduction in the payment for incurred costs. It is not a reduction in the price. It is a reduction of an incurred cost calculation, and it has to be shifted. And there is no way in the world to Mickey Mouse around about denying it.

And finally, it has an additional problem for hospitals with high medicare loads, because their 2 percent then is much greater in volume and much harder to shift.

I would be glad to respond to questions on the other issues, Mr. Chairman. But I did want to bear down on 2 percent. I note in my conclusions on pages 8 and 9, we understand the problem of both the administration and the Congress, not only at the present spending levels but the rates of increase. We are ready to help on major reform and major restructuring, Mr. Chairman, as we have been on consumer choice and prospective payment.

But we have and we must oppose tinkering with this system, because it just does not work.

Thank you, sir.

Chairman Jacobs. Two minutes, 54 seconds. You are looking good, Mr. McMahon. [Laughter.]

Mr. Bromberg.

Mr. McMahon. I need that dollar. I know how to cost shift that one.

Chairman Jacobs. I never have reneged yet. I always put it in the mail the next day or maybe the same day sometimes.

[The prepared statement follows:]

Statement of the American Hospital Association

SUMMARY

Caveat.—Few details of the medicare proposals are available. This statement provides only preliminary comments.

Hearings should be held on the actual legislative proposals.

Background.—Over the past decade, the government failed to control health care cost growth: the attempts were narrowly focused, short-range program changes to achieve budget savings; hospitals worked with government in good faith, but suffered increasing payment shortfalls and were subjected to counterproductive regulation.

Although some of the administration's fiscal year 1983 proposals would repeat past mistakes, there are encouraging signs that the fundamental issue of incentives to patients and providers is being addressed: AHA supports further work on consumer choice/competition proposals; AHA encourages the administration's study of using prospective payment for medicare hospital services.

Only fundamental changes in health care insurance, financing, and payment would permit hospitals to break the current pattern of conflicting pressures: most payments to hospitals are being reduced, yet hospitals must meet escalating demands which they cannot control.

Budget items.—Two Percent disallowance—AHA strongly opposes. Federal employee payment of medicare tax—AHA supports. Eighty-percent reimbursement for radiologists' and pathologists' services—AHA reserves judgment, but points out that beneficiaries would pay the shortfall. Section 223 skilled nursing facility and home health limits—AHA opposes because of medicare's unfair cost allocation rules. Liability waiver repeal—AHA opposes because hospitals would be penalized for good faith efforts and beneficiaries would pay disallowed costs. Contracting initiative—Few details are available. AHA reserves judgment, but opposes repeal of providers' right to nominate fiscal intermediaries because quality service might be jeopardized.

Section 223 limit expansion.—AHA is alarmed at total cost limit regulation under consideration by HHS and some in Congress.

Conclusion.—AHA urges focus on fundamental reforms and end to tinkering with reimbursement system.

STATEMENT

Mr. Chairman, I am John Alexander McMahon, president of the American Hospital Association (AHA). The AHA, which represents over 6,100 member hospitals and health care institutions, as well as more than 30,000 personal members, is pleased to have this opportunity to present its views on President Reagan's fiscal year 1983 budget proposals as they would affect the medicare program.

It is important to note at the outset that my testimony today provides only a preliminary reaction to some of the medicare proposals recommended by President Reagan for fiscal year 1983. Detailed comments must await release of the administration's proposed legislation and a clearer statement of its regulatory initiatives. I hope the subcommittee will provide us with an opportunity to testify on actual legislative proposals before they are considered.

BACKGROUND

The fiscal year 1983 medicare proposals must first be considered in the context of a decade of attempts by four administrations and six congresses to restrain the growth in health care costs, and particularly in federal health outlays. These past efforts amounted to altering the existing reimbursement system to make narrowly-focused, short-range budget savings, while subjecting hospitals to ever-widening payment shortfalls and a heavy burden of regulation that has proved to be ineffective and counterproductive.

In part, the administration's proposals for medicare repeat these past failures, but there are also encouraging signs that the fundamental issue is being addressed of restructuring the entire payment system to provide effective incentives to providers and patients for restraining the rate of increase in health care costs.

We look forward to examining the details of the administration's consumer choice/competition proposal, which we understand will be announced shortly. AHA has encouraged further consideration of consumer choice plans and we have provided advice and assistance to the administration and to Congressional sponsors of such legislation.

AHA also is encouraging closer attention to the possibility of applying a prospective payment methodology to medicare hospital services. We understand that the administration is currently studying ways to implement prospective payment in medicare, and AHA stands ready to provide whatever assistance is requested.

Hospitals, for their part, share the concern of the administration and many in Congress over the continued rapid increase in the cost of providing hospital services, and the resultant pressure on the Federal budget. In good faith, hospitals worked with Government in implementing the professional standards review organization and health planning programs, which at one time appeared to hold the promise of effective cost restraints. Only when it became clear that these programs had become ineffective and therefore needlessly burdensome did hospitals call for their repeal. Hospitals also have worked among themselves to restrain costs, responding to a challenge in 1977 from your committee's chairman to establish, along with other groups in the health care industry, a program known as the voluntary effort (VE). As an interim program the VE worked, against considerable odds in a highly inflationary economy. Now we are actively promoting a new initiative in voluntary cost containment—locally-based coalitions of business, labor, insurers, providers and other interested parties working together to enable hospitals to restrain cost growth more effectively.

But despite hospitals' open efforts, despite reimbursement reductions and despite the now oft-repeated threats by some in Congress and Government, hospitals continue to find themselves stalemated by the entangling web of conflicting pressures and expectations. Payments to hospitals for services are being restricted from virtually all sources, narrowing the options for shifting of shortfalls from one payor to others and jeopardizing some institutions' viability. Yet hospitals are expected to meet increasing demand for health care services under an insurance system, governmental and private, which by providing comprehensive health insurance encourages that demand to grow. The subcommittee should be reminded that Federal and State law combine with community expectations to require that hospitals render care to those who ask for it. As long as those requirements remain, the financing system remains the only mechanism for controlling the growth in health care services without denying needed care. Therefore we must address ourselves to changing that mechanism in ways that will make it more cost effective.

With this background, I would like to comment on several of the budget proposals offered by the Reagan administration as they relate to the medicare program.

Disallow 2 percent of hospital medicare costs.—The Reagan administration proposes to reduce medicare reimbursement to all hospitals 2 percent. In addition, hospitals would be prohibited from billing beneficiaries for these unreimbursed costs. The administration justifies this provision by saying that the proposal would affect all hospitals equally and would be administratively easy to implement.

AHA strongly opposes the 2 percent across-the-board reduction. This proposal neither recognizes the efficient hospital nor spreads the burden equally—two goals of this administration. It actually would penalize those hospitals that have been most active in controlling Medicare costs. Under the proposal, no matter how cost efficient a hospital actually is, it would still be penalized 2 percent of its costs—2 percent below the already significant shortfall in payments hospitals experience for care rendered to Medicare patients.

The 2 percent disallowance also would severely penalize those hospitals with a high Medicare case load. It seems somewhat ironic that, under the Administration's budget proposal, the more committed a hospital is to serving the Medicare population the larger would be its financial shortfall in caring for Medicare patients. Regardless of patient mix, if the 2 percent reduction plan goes into effect, hospitals would be forced to try to shift their costs to other payers. Yet for many hospitals with high Medicare patient loads, which also are likely to have high Medicaid and medically indigent loads, there a few, if any, other patients who can absorb the shortfalls. This proposal could cause severe and irreparable harm to the financial integrity of these hospitals.

Apply the hospital insurance portion of the payroll (FICA) tax to Federal employee wages.—The Reagan administration proposed that the Hospital Insurance portion of the FICA tax, which finances part A of medicare, be imposed on Federal employees' wages beginning in calendar year 1983. AHA supports this proposal as an appropriate public policy decision. While most federal employes currently qualify for medicare at age 65, they do not contribute commensurately to the hospital insurance fund. This proposal would provide equity in the current system and would significantly increase revenues to assure the financial stability of the hospital insurance fund.

Reimburse radiologists and pathologist at 80 percent of charges.—While reserving judgment on this proposal, I must point out the impact which would result. The 20 percent coinsurance which would be instituted for these services would be borne by medicare beneficiaries. For hospitals which have contractual agreements with these specialists the shortfall in reimbursement would necessitate that a hospital bill the patient in order to recover that portion which the hospital owes the specialist by contract. Congress instituted the 100-percent reimbursement and combined billing for these services in large measure to overcome complicated billing procedures which this proposal would reinstate.

Establish a single reimbursement limit for skilled nursing facilities and home health agencies SNF/HHA reimbursement.—The Administration proposed to establish a single reimbursement limit on reasonable costs for hospital-based and freestanding skilled nursing facilities (SNF's) and a single limit for hospital-based and freestanding home health agencies.

AHA opposes this provision because it does not take into account the cost differences resulting from medicare reimbursement rules on overhead charges and other associated costs. Further, it does not account for the more severely ill patients treated by hospitals and the complicated and intensive services hospitals provide. If medicare should implement this proposal, the medicare cost allocation rules must be changed to permit hospitals to allocate only the actual costs involved in providing these services.

Eliminate waiver of liability.—This proposal would eliminate the waiver of liability afforded to an institutional provider when medicare claims are disallowed because the care was deemed after the fact as not "medically necessary" or not a medicare covered item, even when the provider is totally without fault.

The AHA believes there is no reason to penalize hospitals which have made efforts in good faith to provide needed services—services ordered by physicians and other professionals. There is no evidence that hospitals have abused this waiver authority. Repealing it would only increase existing bad debt problems, and force hospitals to take measures to assure that their services will be paid for—services which may prove to be uncovered through no fault of the patient or the hospital.

Change medicare contracting initiative.—There are virtually no details available regarding this element of the administration's budget, except that savings in excess of $300 million are anticipated. One facet merits comment at this point—the proposal to terminate the providers' right to nominate the medicare fiscal intermediary with which they will work. AHA continues to support the current arrangement, which has proved to be workable and which allows the Health Care Financing Administration to overturn the providers' nominations if they are unacceptable. Provider-intermediary relationships are crucial to the smooth operation of the medicare program, with its myriad rules and procedures, and the constant flow of program changes which affect reimbursement. We believe that whatever savings might be achieved through other intermediary selection procedures, which emphasize price as the primary criterion, would be more than offset by the disruption of the day-to-day operation of the medicare program.

Expand section 223 limits.—Although not included in the administration's fiscal year 1983 budget recommendations, expansion of controls under section 223 (of Public Law 92-603)[1] is under active preparation at HHS. We understand these new controls would apply to total medicare hospital costs on a per admission basis with the possibility of some type of hospital case mix adjustment factor.

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[1] Section 223 provides broad authority to the Department of Health and Human Services to impose limits on medicare reimbursement to hsopitals and some other providers.

The AHA is quite alarmed over the possible extension of these limits to total costs. We view extension of section 223 authority as merely a mechanism to deny hospitals reimbursement for the true cost of providing necessary care. The Department of Health and Human Services has had difficulty in developing an equitable and workable methodology for this type of regulation. We take the opportunity today only to raise the issue.

CONCLUSION

Mr. chairman, the administration's fiscal year 1983 medicare proposals contain both encouraging and discouraging elements. To the extent these proposals move toward addressing fundamental questions of restructuring health care financing, AHA recommends further consideration and development. By contrast, those punitive measures which would repeat the same mistakes made in the past should be rejected and energy focused on more productive work.

We understand the budgetary pressures on Congress and the administration and stand ready to participate in major reforms which will move toward solutions of those budgetary problems and reduction in the growth of health care expenditures. We cannot accept mere tinkering that imposes the wrong incentives on medicare patients and providers. We look forward to working with you on fundamental change.

Chairman **Jacobs**. Mr. Bromberg.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

Mr. **Bromberg**. Mr. Chairman, I would like to say that I think both the 2 percent proposal and the testimony and the questioning today on cost shifting in general has served a very great educational purpose. One thing I would like to point out, this has been going on for 16 years and perhaps it has only been because of the massive advertising and some other questions that it is finally out of the closet and onto the table. We have had cost shifting since the first year of the medicare program. Year after year, as more cuts came, there was shifting.

It might also be worthy to point out that were we to get rid of cost shifting and were medicare not to have a 24-percent discount, in order to pay its fair share it probably would have to raise payroll taxes, which is a fairly regressive tax, rather than shifting it to what may be large employers and group health insurance policies. This needs to be put on the table.

In our testimony we oppose the 2 percent solution very strongly. We also oppose several of the cuts. But in an effort to try to give the committee some guidance for its March 15 recommendation to the Budget Committee, which is the purpose of this hearing, we have listed a four-point program on page 2 of our testimony. The four points include two which we believe would have immediate first-year budget savings or revenue-increasing impacts. The second two are proposals which we believe would save money, not in the first year of their implementation, but possibly in the second and certainly in the third.

At the end of our testimony there is a chart which I would refer the committee to on page 12, which shows that if two proposals were enacted this year by the Congress, a tax ceiling on health insurance above $150 a month and a benefit restructuring with cost sharing, that the CBO numbers on both of these proposals have up to first year savings of $3.7 billion in terms of reducing the deficit, and by 1987 $10 billion.

The other two proposals we recommend, a prospective rate and a medicare voucher option, would we believe over the 5-year period save significantly more money. We would like to leave you with those recommendations in terms of what you may or may not wish to recommend to the Budget Committee.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

SUMMARY

We urge you to reject arbitrary cuts in the Medicare budget which do not reform the current system. Instead we urge you to accelerate efforts to bring marketplace competition and restraints on utilization to the system by enacting the following legislative proposals: First, a ceiling on tax-free employer purchased health benefits designed to encourage the offering of multiple insurance plans; second, benefit redesign to require reasonable cost sharing by medicare beneficiaries during the first 30 or 60 days of a hospital stay up to a catastrophic level in order to encourage restraint in utilization; third, a voluntary medicare private insurance option as proposed in H.R. 4666 sponsored by Representatives Gephardt and Gradison; and fourth, development of a medicare prospective payment schedule for hospital services and the elimination of cost reimbursement.

These four changes would address the underlying problems in the current system and would alleviate the need for arbitrary cuts in the medicare program. Enactment of a ceiling on tax-free health benefits and passage of medicare benefit redesign with restructuring of cost sharing would produce immediate budget savings and increased revenues substantially in excess of those cost reimbursement cuts which we oppose. These two proposals could reduce the budget deficit by more than $3 billion compared to the $1.1 billion in hospital cuts contained in the proposed fiscal 1983 budget. Enactment of a medicare voucher option and a prospective rate system might not produce immediate first year savings but would produce substantial dollar savings in the second and future years.

We strongly oppose the proposed 2-percent cut in cost reimbursement to hospitals. It is an arbitrary proposal which calls for an across the board cut to all hospitals, disregarding their relative efficiency, costs or caseload.

STATEMENT

Mr. Chairman and members of the subcommittee, my name is Michael D. Bromberg, executive director of the Federation of American Hospitals.

The Federation of American Hospitals is the national association of investor-owned hospitals and hospital management companies, representing over 1,000 hospitals with over 115,000 beds. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all nongovernmental hospitals. In many communities investor-owned facilities represent the only hospitals serving the population.

We appreciate this opportunity to react to the fiscal 1983 Medicare budget cuts proposed by the administration. In general we have serious reservations about the short-term reductions in hospital reimbursement contained in a list of proposed regulations and proposed legislation. These short-term savings total more than $1.1 billion in hospital reimbursement arbitrarily reduced by strained attempts to justify new definitions of allowable cost reimbursement.

This annual charade has been going on since 1966; however, the scope of the reductions in cost reimbursement has reached an all time high this year. Proposed cuts in hospital reimbursement are two and three times higher than proposed cuts affecting other providers and beneficiaries. As we address these individual cuts and express our opposition to them, it is important to keep in mind that all of the short-term proposals are directly related to definitions of retrospective cost reimbursement, a system which pays too little and contains perverse incentives.

This administration, like others before it, recognizes that cost reimbursement has fueled health expenditure increases and needs to be replaced by a system which turns around the incentives in order to reward management efficiency and restrain utilization. We are very supportive of the system reform proposals being developed by the administration and by members of this committee. Specificially we urge you to reject arbitrary cuts in the medicare budget which do not reform the current system. Instead we urge you to accelerate efforts to bring marketplace competition and restraints on utilization to the system by enacting the following legislative proposals: First, a ceiling on tax-free employer purchased health benefits, designed to encourage the offering of multiple insurance plans; second, benefit redesign to require reasonable cost sharing by medicare beneficiaries during the first 30 to 60 days of a hospital stay up to a catastrophic level in order to encourage restraint in utilization; third, a voluntary medicare private insurance option as proposed in H.R. 4666 sponsored by Representatives Gephardt and Gradison; and fourth, development of a medicare prospective payment schedule for hospital services and the elimination of cost reimbursement.

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Comments on Specific Administration Proposals

TWO PERCENT REDUCTION IN MEDICARE HOSPITAL REIMBURSEMENT

This proposed amendment would reduce medicare hospital reimbursement from 100-percent allowable cost reimbursement to 98 percent of allowable costs. It would cut payments to hospitals by $653 million even though these dollars represent actual hospital expenses. Medicare reimbursement is already far below what can be considered fair payment for services rendered to program beneficiaries. This arbitrary proposal calls for an across the board cut to all hospitals, disregarding their relative efficiency, costs or caseload. We strongly oppose this inequitable cut. We cannot find any merit to the proposed two percent cut which does nothing to resolve the real causes of increasing costs in the medicare program.

REPEAL WAIVER OF PROVIDER LIABILITY

This provision would repeal a prior amendment passed by Congress to protect both hospitals and patients from retroactive denials of reimbursement for services reasonably believed to be necessary at the time rendered but subsequently found to be unnecessary.

We believe Congress was correct in its prior decision to enact this change, particularly since physicians rather than hospitals order these services. By imposing penalties on the hospital under part A reimbursement, the proposed repeal would be most inequitable.

MEDICARE CONTRACTOR INITIATIVE

This legislative proposal would eliminate provider nomination of intermediaries and we believe such a change is unnecessary. Under present law the Secretary may reject an intermediary nomination where he finds it is not in the best interest of efficient and effective administration. The proposed amendment would take away the due process right of providers or intermediaries which requires the Secretary to make that decision based on published standards and criteria for efficient and effective administration.

We believe that experimentation with negotiated fees between the Secretary and intermediaries can be conducted without sacrificing competition by simply allowing all intermediaries to contract at the fixed fee rate and retaining a pluralistic intermediary system.

LENGTH OF STAY-UTILIZATION REDUCTION PROGRAM

This regulatory proposal is estimated to save $330 million. While details have not been released, we believe the program will include instructions to medicare intermediaries in areas of high average length of stay or high utilization to reduce hospital utilization by various means. We believe this approach has some merit provided it does not lead to arbitrary actions and a return to problems encountered in early years of the program when retroactive denials were more common than today.

Since physicians, not hospitals, are legally and medically responsible for determining length of stay and utilization of services, it would be unfair to penalize hospitals retroactively for orders issued by physicians. Where utilization decisions are properly reviewed by hospital review committees, no penalty should by imposed in the absence of prospective guidelines. We will want to carefully study the details of this program when they are published.

ELIMINATION OF PSRO PROGRAM

We support the proposal to repeal the PSRO program. We believe the private sector can do a better job in evaluating utilization decision then a regulatory program. We will study forthcoming proposals to establish a program for contracting out this function on a limited basis. This is an area where local coalitions can play a meaningful role.

ELIMINATE PRIVATE ROOM SUBSIDY

This regulatory proposal would reduce cost reimbursement by offsetting private room revenues from certain medicare patients who voluntarily elect such accommodations. The administration argues that private room costs should be excluded from routine cost finding under medicare; however, medicare regulations do not allow hospitals to separately identify medicare private room or subintensive care unit costs. We oppose the regulatory proposal as presented by the administration and instead urge you to specify that additional cost centers be allowed in the cost finding process for these types of services.

COST SHARING

The administration budget documents discuss cost sharing in connection with the health care competition proposal to be submitted to Congress in the near future. Part of that plan will call for a modest coinsurance rate on all hospital days following the first day and will provide catastrophic coverage, including unlimited hospital days, limiting total cost sharing under parts A and B to $2,500 per year. No budget savings are projected since the details of the plan have not been finalized. The Congressional Budget Office has estimated that 10 percent of the deductible cost sharing from the second day through the 30th day would save over $1 billion in the first year.

More important then sharing costs is the impact that consumer participation would have on utilization.

A large body of economic analysis strongly supports the conclusion that financial incentives have a significant impact on utilization. Utilization goes down as cost sharing goes up. Here are some typical findings:

A 10-percent increase in the price of inpatient services reduces demand between 5 and 7 percent. (Feldstein, Martin, "The Welfare Loss of Excess Health Insurance," Journal of Political Economy, 1974.)

A 100-percent decrease in the price of ambulatory services would raise demand by 120 percent. (Newhouse, Joseph, Charles Phelps, and William Schwartz, "Policy Options and the Impact of National Health Insurance," New England Journal of Medicine, 290 (1974) pp. 1345–1359

INCREASING DEMAND

Because the proportion of the population over 65 will increase markedly over the next decade, the untilization of health care services per capita is expected to increase dramatically under the status quo. Medicare expenditures, even after being adjusted for inflation, are expected to increase by 60 percent from 1980 through 1985.

Among the major contributing factors to hospital cost increases are admissions and intensity. The percentage increase in total hospital admissions has been stable at between 2.5- and 2.9-percent annually since 1977 except for a relatively low 0.4-

percent increase in 1978. The intensity increase has been caused primarily by increased admissions of patients over age 65.

The cost of treating over age 65 patients generally is more than two times the cost of treating patients under age 65 in hospitals. The following chart illustrates the admission intensity trend:

PERCENTAGE INCREASE IN ADMISSIONS

	1978	1979	1980	1981
Under age 65	1.0	1.7	1.5	0.4
Age 65 and older	4.9	5.3	6.7	5.3

The intensity area also includes technological advances which save and prolong lives and are costly. There are many social, ethical and economic questions which can be raised in this area, but an aging society demands more intensive health care.

During the past 12 months admissions of over age 65 patients rose about five times the rate of under age 65 admissions. Demand is the single most serious aspect of hospital cost increases and until demand is addressed, there will be no solution to health care inflation.

A MARKET STRATEGY

The large body of studies examining the causes of health care expenditure growth all point to the same conclusion: The problem is not inefficiency but utilization—patients, freed from the burden of payment, demand more; and physicians, unrestrained by cost-based reimbursement, provide more.

Our present system of health care financing has desensitized providers and consumers to the true costs of health care through the extensive use of first dollar coverage and low copayment rates. The situation has been aggravated by cost reimbursement which encourages excessive spending. The result is intense quality competition but little price competition.

Restoring cost consciousness to providers and consumers is intrinsic to any solution to rising health costs. Without price awareness, demand for health services is infinite. That is why we urge you to substitute proposals for a ceiling on tax free health insurance premiums, cost sharing, a voucher option, and a medicare prospective payment system for the cuts proposed by the administration in medicare reimbursement.

OTHER REGULATORY OPTIONS

Two regulatory cost control options which have not been recommended by the administration in its budget proposals are expansion of section 223 limits to all medicare hospital costs per admission or reliance on State rate controls. We strongly oppose both of these measures. Each of these options involves a significant increase in regulatory costs with little promise of results.

Section 223 limits on per admission costs would require use of a complex methodology for grouping hospitals and case mix. A large number of exception requests would be filed as every hospital argues that it differs from others due to the mix of patients and diagnoses. Physicians would be tempted to upgrade diagnoses and admit marginal cases to maximize reimbursement. A larger bureaucracy would be needed to administer this kind of program. There would be no incentives for efficiency since the system would still be cost based.

A review of state rate controls indicates little difference in expenditure growth on a per capita basis between the seven states with controls and all other states. 1980 per capita hospital costs rose 13.6 percent in rate control states compared to 13.7 percent in all other States—an insignificant difference. When New York is excluded, the per capita increase was 1.2 percentage points greater in the rate control states—14.9 percent compared to 13.7 percent for noncontrol states. Maryland also incurred per capita increases of 13.9 percent—also above the increase for other states.

Hospital care is more expensive in states with mandatory rate setting programs. In 1979, per capita hospital expenditures for the seven States with mandatory programs were $305 versus $272 for nonmandatory states.

New York, which has the oldest and most advanced rate setting program, also has a hospital system which is in very poor financial health. Between 1974 and 1978, New York voluntary hospitals had to use almost $500 million in hospital reserves to finance current operating losses. At that rate it will only take 15 years before the total equity of all the 222 voluntary hospitals in New York is consumed. Although demand for services and patients served increased during the 1974 to 1978 period, the number of voluntary and public hospitals declined 5.4 percent.

Although New York has reduced its hospital expenditure growth rate more than any other mandatory rate setting State, the penalty probably is more than other States would be willing to bear. Liquidating a hospital system to save money is like demolishing the rooms of a house to cut energy costs.

These regulatory strategies cannot be effective without sacrificing quality and we urge you to reject them.

MEDICARE PROSPECTIVE RATES

After fifteen years of rhetoric on the perverse incentives of cost reimbursement, we believe it is time to develop a medicare prospective payment system.

A new system acceptable to the Government should certainly include budget savings and predictability, administrative simplicity, incentives for efficient delivery of services, the ability to install the new method quickly, and consistency with the competition strategy.

The hospital industry will certainly want assurances that the new system will be equitable, will enable hospitals to recover their full financial requirements and involve less regulation.

Other third-party payors will look at the system to see whether it minimizes cost shifting.

Beneficiaries will certainly be concerned about the scope and equity of any cost sharing elements as well as freedom of choice of providers.

The concerns of the various parties involved can all be satisfied by following these guidelines: First, establish a prospectively determined medicare payment schedule; second, permit hospitals to charge beneficiaries the difference between the medicare rate and hospital charges up to some catastrophic level; third, recalculate the medicare rate annually based on average charges or based on an index which reflects hospital input price and wage increases and capital costs in a geographic area; and fourth, avoid complex formulae which rely on diagnostic related groupings and which result in a large number of exception requests.

These principles would assure hospitals of the opportunity to recover their financial needs (although it would not guarantee recovery if their prices are too high). They would assure beneficiaries of catastrophic protection which they do not have under current medicare law. They would minimize cost shifting by redesigning the time of copayment. They would save dollars and provide budget predictablity to Government. Finally, they are consistent with the competition strategy of the administration stressing consumer choice and incentives for restraint in utilization.

This is truly an historic proposal whose details as of now are unknown but whose objectives are timely and virtually uncontested. The hospital industry owes it to the public, Government, and itself to carefully and constructively review the administration's plan when it is unveiled in the near future. It may well turn out to be revolutionary enough to free hospitals from arbitrary medicare regulations and from the future threat of even more arbitrary cutbacks in payment for quality care.

We are anxious to work with the committee members and staff to explore the idea of developing a medicare prospective payment schedule as soon as possible.

CONCLUSION

Last year's Reconciliation Act cut medicare expenditures by more than $1 billion. The administration's fiscal year 1983 budget proposes a $2.5 billion reduction in medicare. Cuts of this magnitude without true reform are intolerable.

We urge this committee in its recommendations to the Budget Committee on the First Budget Resolution to modify the administration's proposed spending levels for medicare and to immediately address the underlying problems of the current system through changing tax incentives, restructuring beneficiary cost sharing, providing a Medicare private insurance option and developing a prospective payment system for Medicare.

Passage of a tax on employer-paid health insurance in excess of $150 per month for a family of four and the restructuring of patient coinsurance could reduce the fiscal 1983 deficit by $3.7 billion and would save $10 billion in fiscal 1987 according to Congressional Budget Office estimates.

[In billions of dollars]

	1983	1987
Revenue Gain		
Tax excessive employer-paid health insurance:		
Income tax	$2.0	$6.0
Payroll tax	0.6	2.1
Subtotal	2.6	8.1
Expenditure Reductions		
Restructuring coinsurance: Savings	1.1	1.9
Total reduction of budget deficit	3.7	10.0

Source: CBO Report, "Reducing the Federal Budget Deficit,," February 1982, pp. 196, A-72, B-40.

If these two changes in the law were coupled with passage of a voluntary medicare voucher option and a prospective Medicare hospital payment system, savings would increase substantially in fiscal 1984 and could double by fiscal 1987.

Mr. Chairman, we thank you and the members of the subcommittee for this opportunity to present our association's views on the proposed medicare budget.

Chairman JACOBS. Would you believe 2 minutes, 10 seconds?

Mr. Bromberg—Mr. Duncan. I am sorry.

Mr. DUNCAN. Since we have a rollcall, I perhaps would like to submit some questions in writing to the panel. They may respond in writing.

Chairman JACOBS. OK. Mr. Bromberg——

Mr. DUNCAN. May I have unanimous consent?

Chairman JACOBS. Without objection, it is so ordered.

[No questions were submitted.]

Chairman JACOBS. Mr. Bromberg, I was handed a question which I will pose to you as stated. It was reported that hospitals had indicated to the administration that they supported this 2-percent reduction as an alternative to certain other budget cuts, such as: One, reduction in the return on equity; two, treatment of interest on funded depreciation; or three, section 223 limits on ancillary costs.

And the question is: Which of these methods of reducing Federal spending in 1983, fiscal 1983, do you prefer? And if that is not a question along the lines of, would you rather die by sword, fire or drowning, could you give some response?

Mr. BROMBERG. Well, I think that is the answer to the question. There are two answers. First, in our testimony we give you four other alternatives worth about six times as much money, and I think that is our preferred answer.

But second, to be truthful, I do believe if you are going to give the administration credit for anything, it is honesty. I think the proposal is terrible and unfair and inequitable. But at least it is an absolute open admission that what they are doing is simply budget scraping, a proposal which they know is going to be shifted. And obviously we think it would be a worse step in the wrong direction to go to a very complicated regulatory, 223-type system, which would lead us down the wrong road, toward a prospective rate which we believe would be very regulatory, whereas we are supporting movements toward a prospective rate which we hope will be more simple, easier to administer, easier to understand, and a lot fairer in terms of its reimbursement equitability.

So the answer to your question is, yes, I think there are things I could dream up that are even worse than 2 percent. But I think we have offered you four other alternatives which we think are better and save a lot more money.

Chairman JACOBS. Well, I suppose maybe one other alternative is to skip the fun and games in El Salvador. But I guess that is not relevant to these hearings.

We thank you for the testimony.

The next panel consists of a representative of the American Medical Association, Daniel T. Cloud; and the American College of Emergency Physicians, Dr. Henry Sabatier, and their associates.

I am sure you gentlemen have heard the rules of the New York Athletic Commission and all that, so proceed with that understanding.

STATEMENT OF DANIEL T. CLOUD, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY FRED C. RAINEY, M.D., CHAIRMAN, COUNCIL ON LEGISLATION; AND ROSS N. RUBIN, DIRECTOR, AMA DEPARTMENT OF FEDERAL LEGISLATION

Dr. CLOUD. Mr. Chairman, my name is Daniel T. Cloud, M.D., and I am a pediatric surgeon in private practice in Phoenix, Ariz., and I am president of the American Medical Association. With me is Fred C. Rainey, M.D., a physician in family practice in Elizabethtown, Ky., who is chairman of the AMA's Council on Legislation. And accompanying us is Ross N. Rubin, director of AMA's Department of Federal Legislation.

The American Medical Association is pleased to have this opportunity to appear before your committee today.

Mr. Chairman, in recent years the expansion of entitlement programs within the Federal Government has led to the situation where Congress had little control over the major portions of the Federal budget. Now that Congress has made significant program changes in discretional funding, Congress should turn its attention to the form of entitlement programs.

We have been asked to appear today to comment on changes in the medicare program proposed by the administration and designed to generate approximately $3 billion in Federal budget savings.

Respectfully, we do not intend to address those cuts today, Mr. Chairman, because we believe that addressing individual items and particular programs does not provide the direction and leadership necessary to chart a course for the delivery of health care in this country for this and future decades.

Rather, Mr. Chairman, we believe it is now time to step back from that pattern of looking at individual program budgets and attempt to place in perspective the role of the Federal Government in financing and delivering medical services in the future. Now is the time to set priorities for the future and not continue to deal with crises on an annual basis.

Mr. Chairman, we believe it is essential to design a fundamental, coherent long-range national policy on health care, a policy that realistically addresses the quality, accessibility and cost of health care and the role of Government at all levels in these efforts.

The American Medical Association will take the initiative in this area. There is a need for evaluation of long-term health policies that will lead to proper care for our citizens within the available national resources. We have begun such an evaluation and will make recommendations concerning health care, both long and short term.

In our view, Mr. Chairman, there should be no sacred programs. A primary goal should be to meet the needs through Government resources for those not able to provide for themselves.

Today we will not address certain program provisions that specifically address provider or physician reimbursement. We believe the time has passed for comments that emphasize only that approach.

We would ask all interested health groups, whether they appear here today or not, to put aside individual self-interest and join us in evaluating the overall situation with a long-term perspective.

Mr. Chairman, the answers to our health problems are not to be found in arbitrary caps, in inequitable benefit reductions, in arbitrary cost shifting, or in quick-fix expediency. Solutions will be found only when all interested parties participate in a basic restructuring of Federal programs.

The American Medical Association is committed to a leadership role in setting a new course. We recognize that in an era of finite resources we must all work to establish the course that will continue to provide the finest health care system in the world.

I want to make it plain that this statement is a clear signal that the American Medical Association intends to step away from the status quo and embark upon a comprehensive assessment of Federal programs for health care that will assure that quality and accessibility of care for patients will be preserved within the available national resources.

We pledge you our best effort. Thank you.

[The prepared statement follows:]

Statement of the American Medical Association, Presented by Daniel T. Cloud, M.D., and Fred C. Rainey, M.D.

Mr. Chairman and members of the subcommittee, my name is Daniel T. Cloud, M.D. I am a pediatric surgeon in practice in Phoenix, Ariz. and am president of the American Medical Association. With me is Fred C. Rainey, M.D., a physician in family practice in Elizabethtown, Ky., who is chairman of AMA's Council on Legislation. Accompanying us is Ross N. Rubin, director of AMA's Department of Federal Legislation.

The American Medical Association is pleased to have this opportunity to appear before the committee today.

Mr. Chairman, this Nation is facing many problems. Unemployment is continuing to increase. Interest rates are not dropping as quickly as had been anticipated, and the projected $100 billion Federal budget deficit will most likely continue to place upward pressure on those interest rates.

The American Medical Association is committed to an economy characterized by strong, real growth. Reaching this goal is absolutely necessary to ensure a quality living standard for all our citizens.

Last year when the President called for significant cuts in nonentitlement programs, Congress responded and at the same time began the transfer of federal categorical grant programs to the States. We are now beginning to see the first results of this action. There are significant reductions in the increases in the cost-of-living and a moderating trend in interest rates.

However, in recent years, the expansion of entitlement programs by the federal government has lead to the situation where Congress has little control over the major portions of the Federal budget. Now that these major program changes are in place, Congress should turn its attention to reform of entitlement programs.

We have been asked to appear today to comment on changes in the medicare program, proposed by the administration, designed to generate approximately $3 billion in Federal budget savings. We do not intend to address those cuts today, Mr. Chairman, because we believe that addressing individual items in particular programs does not provide the direction and leadership necessary to chart a course for the delivery of health care in this country for this and future decades. Rather, Mr. Chairman, we believe it is now time to step back from the pattern of looking at individual program budgets and attempt to place in perspective the role of the Federal Government in financing and delivering medical services in the future. Now is the time to set priorities for the future and not continue to deal with crises on an annual basis.

The American Medical Association intends to take the initiative in this area. The Association sees a need for an evaluation of long-term health policies that will provide proper care for our citizens within the available national resources. We are undertaking such an evaluation and will make recommendations concerning health care, both long and short term.

In our view, Mr. Chairman, there should be no sacred programs. A primary goal should be meeting the needs through governmental resources for those not able to provide for themselves.

Mr. Chairman, health care is too important to be placed within a Cabinet Department that has a major share of its activity devoted to welfare. A rational system would place health care matters within a distinct Department of Health, both at the Federal and State levels.

Today we have not spoken about certain program provisions that specifically address provider or physician reimbursement. We believe the time is past for comments that emphasize only that approach. We would ask all interested health groups, whether they appear here today or not, to put aside individual self interest and join us in viewing the overall situation with a long-term perspective.

Mr. Chairman, the answers to our health problems are not to be found in arbitrary caps, in inequitable benefit reductions, in arbitrary cost shifting or in quick-fix expediency. Solutions will be found only when all interested parties participate in a basic restructuring of Federal programs.

The American Medical Association is committed to a leadership role in determining a new course. We recognize that in an era of finite resources we must all work to establish a course that will continue to provide the finest health care system in the world.

Mr. **Anthony** [presiding]. You have me in a real interesting spot. I had gone over to vote. I have come back. I have not even heard your 4 minute and 33 second testimony. My apology for not hearing your testimony, but I will have an opportunity to read your written statement. If it holds up to the quality of the previous witnesses, I am sure it will provide a very constructive contribution to the committee as we deliberate these. And with that, my thanks to you for appearing.

All right. The American College of Emergency Physicians, Henry S. Sabatier. Is that correct?

Doctor, it is all yours.

STATEMENT OF HENRY S. SABATIER, M.D., CHAIRMAN, GOVERNMENT AFFAIRS COMMITTEE, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Dr. **Sabatier**. Thank you, Mr. Chairman.

My name is Henry Sabatier, M.D. I am a practicing emergency physician at National Hospital for Orthopedics and Rehabilitation in Arlington. I represent the American College of Emergency Physicians.

We are a 12-year old organization which has a membership of approximately 10,000 physicians who specialize in the practice of emergency health care. We are always on duty 24 hours a day, 7 days a week. We are available at all times and never turn patients away. We see all patients regardless of ability to pay. We see patients with all degrees of illness and injury from the worried well and those with minor injuries to those with heart attacks and victims of disasters.

To give you an example, when President Reagan was rushed to George Washington Hospital after the attempt on his life, the first physicians who treated him were emergency physicians. When Air Florida Flight 90 went down in the Potomac on January 13, I was on duty in the emergency department and received five victims within the space of a few minutes.

But most important, should there come a time when you or your child or your parent needs urgent health care, one of the members of our college will be on duty in an emergency department available to treat you.

Unfortunately, in our daily practice we see far too many cases of patients who have experienced delays in getting treatment or who have neglected serious conditions until they finally become emergencies. This results in needless disability, long recovery time and sometimes premature death.

When the medicare and medicaid programs were enacted in 1965, a bright promise was made to the American public, and that promise was that people who were old or poor and became sick would be in the mainstream of American medicine and receive the finest available health care.

We are part of the medical profession and the health care industry which redeems that promise. Unfortunately, in many instances we find that the Government does not want to pay for that promise.

We know that there are many problems in these programs in design, coverage, and administration. We share the confidence of the American Medical Association that these can be worked out with the primary goal of protecting the health of Americans.

As you reflect on the changes that you may contemplate in these programs, we ask you to consider three important points. First, please do not discourage patients from seeking care in a timely manner by burdening them with additional deductibles and coinsurance. Second, do not drive away any more physicians or hospitals from participating in these programs by further arbitrary cuts in reimbursement. And third, we would support the position of the American Hospital Association and others that cost shifting is really a dishonest sort of indirect tax on other payers of health care; that is, patients who pay for insurance premiums and patients who pay for their own care. Shifting these costs will not make them go away. These costs are made up of wages, salaries, buildings, supplies, equipment, utilities, insurance, and so on, and shifting them around is really just another form of taxation on other patients.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Mr. Chairman and members of the committee, I am Henry S. Sabatier, M.D., a practicing emergency physician in Metropolitan Washington where I serve as Director of the Department of Emergency Medicine at National Orthopedic and Rehabilitation Hospital in Arlington, Va. I appear before you today as the representative for the American College of Emergency Physicians in which I serve as chairman of the Government Affairs Committee.

THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

The American College of Emergency Physicians (ACEP) was founded in 1968 by a group of physicians responding to the growing public demand for the improvement of the care and treatment of medical emergencies. ACEP has grown rapidly and now has over 10,000 members whose primary interest is the support and promotion of excellence in the delivery of emergency medical care.

We seek to accomplish this objective through a variety of aggressive, innovative programs, primarily in the area of education. The college sponsors national and regional scientific meetings, conferences and seminars for the exchange of professional information with leaders in the community of emergency medicine. ACEP also makes available informed representatives to the local and national councils of government to assist in governmental efforts to formulate national policy.

There is a continuing need for a concerted national effort to improve emergency medicine and to encourage and facilitate the practice of emergency medicine. For example:

First, accidental injury, while on the decline, is still the leading cause of death among persons between the ages of 1 and 44 years.

Second, cardio-vascular disease is the number two killer in the United States today accounting for over one million deaths. Of these, nearly one-third were in the category of sudden death due to heart attack.

Third, over 6,000 deaths annually are attributed to poisonings and over 7,000 annually are attributed to the results of serious burn injuries.

We are not pleased with these statistics, but they do reflect an improvement over the years. Nevertheless, the incidence of unnecessary death and disability that can be attributed to inaccessibility of appropriate emergency intervention is far too high. This country has the needed knowledge and technology but it is still not being made uniformally available. Rural and inner-city hospitals, in particular, have often lacked physician coverage of the emergency department and many emergency physician groups are providing needed emergency coverage for these communities.

EMERGENCY MEDICINE AND EMERGENCY MEDICAL SERVICES TODAY

On January 13, 1982 I was on duty in the emergency department of National Orthopedic and Rehabilitation Hospital when the tragic Air Florida Flight 90 went down into the Potomac River. At that time, an unknown number of survivors were anticipated into various hospitals in the middle of a snowstorm at rush hour. Our hospital mobilized itself and received for treatment five of the crash survivors.

This event is an example of the total, unpredictability of the type of practice that we have in emergency medicine. It is often feast or famine. This year, over 80 million visits by patients to emergency rooms and emergency departments throughout the country will occur. Emergency physicians are fully trained, fully experienced physicians, who specialize in the treatment of acute illness and injury. We are on duty 24 hours a day in hospitals, 7 days a week. We are always available and never turn patients away. Ten years ago, if you were taken into an emergency room you might have been treated by an intern, a newly graduated physician—the least experienced member of the team treating the most seriously ill and injured patients. Today that situation would be reversed. You would have a trained and experienced physician to care for you. Patients are seen without regard to their ability to pay. All patients are seen irrespective of their degree of illness or injury, from the worried well and those with minor injuries to the victims of heart attacks and major disasters. Many of our patients are old and sick and poor. Many of our patients are beneficiaries of the medicare and medicaid programs. We would also observe, that many of our patients have found medical care either inaccessible or associated with a great deal of inconvenience because physicians and hospitals alike have chosen not to participate in the medicare and medicaid programs. We have learned that this negative participation is because of long delays in payment, and when payment finally does occur, it is often 60–75 percent below the usual charges and/or costs. Sometimes, this does not even make up the cost of the care provided by the physician or hospital. Almost all of the physicians of the American College of Emergency Physicians participate in medicare and medicaid and we accept whatever payment the Government decides is appropriate. Unfortunately, as part of our practice, we are daily confronted by patients who have experienced delays in getting treatment or who have neglected serious conditions until they finally become emergencies. This results in needless disability, long recovery time, and sometimes premature death.

In 1965, when medicare and medicaid were enacted, I was just entering medical school. My entire professional life has been in the era when the Federal Government exercised some responsibility for the care of the old and the poor. I do not remember what it was like to practice in the era when there were vast charity wards in hospitals, most doctors took care of some people who could not pay their bills or when a lot of people just went without care and ended up coming into an emergency room in a far-advanced state of illness.

Seventeen years ago, when these programs were enacted, there was a bright promise made to the American public. That promise was that people who were poor or old and became sick would be in the mainstream of American medicine and have the best available health care. We are part of the medical profession and health care industry which helps to redeem this promise that was made to the American public. Unfortunately, in many instances, the Government does not pay for this promise. We know that these programs are becoming expensive. We know that they have many problems in design, coverage and administration.

We have seen a steady erosion of that promise as the Government cuts back on its willingness to pay for bills for services rendered. We see constant headlines about the soaring cost of health care when, in fact, what is happening is that many millions of people are receiving care who were not in the health care system 10 to 15 years ago. In addition, more and more people are getting better and better health care with the emergence of new health care technologies.

THE ISSUES

Mr. Chairman and members of the committee, I would like to address several specific issues in the administration's budget concerning "provider reimbursement reforms."

UPDATE THE PART B FEE SCREEN ON OCTOBER 1

As explained in the administration's documents, changing the part B fee screen update from July 1 to October 1 appears to be a little housekeeping change since the Federal Government budget year changed from July 1 to October 1. Let me take a moment to explain how the fee screen is determined.

The fee screen year currently starts on July 1 of each year and is based upon the fees charged throughout the community during the previous calendar year. This, in fact, means that the annual updating of the allowable, reasonable fees is at least 6 months behind and can be up to 18 months behind. This proposal would add an additional three months.

It would appear then, that to be more equitable, a revision of the data base in determining the fee screen should also occur. What has occurred in the past several years is a continuing decline in the percentage of doctors who are willing to take assignment under Medicare. That is, those willing to accept medicare's allowed fee screen as payment in full. The gap between these allowed fees and the general level of fees in the community has become wider and wider. Now, less than 50 percent of the doctors in the United States are willing to accept medicare assignment routinely. As physicians drop out of medicare assignment, this results in shifting the costs more and more to the beneficiary.

LIMIT INCREASE IN THE MEDICARE ECONOMIC INDEX TO 5 PERCENT

This proposal would limit the increase in the medicare economic index for prevailing charges to 5 percent. The medicare economic index is designed to limit increases in physician charges to a percentage of last year's charges. It is derived by taking into account all of the costs incurred by a physician providing medical services. The last time that I looked at the economic index and at the breakdown of costs, they indicated that the malpractice insurance has gone up 10 percent. I doubt if you can find a single state where malpractice insurance has only gone up 10 percent. In New York State it has gone up 100 percent. My own malpractice coverage increased 30 percent last year. This is an example of a very unrealistic limitation.

The cost to a physician for provision of medical services to the American public goes up approximately at the same rate as inflation. These costs, chiefly wages, rent, supplies and utilities would be limited to an arbitrary 5 percent resulting in another decrease in the percentage of doctors who are willing to accept medicare assignment and increasing the numbers of physician costs being charged indirectly to the medicare beneficiary. Contrary to the administration's suggestion, this would not "* * * be a one-time change for physicians to share the burden of slowing the growth of health care expenditures at a time of severe constraints." This would be an on-going and progressively increasing action. Reference is made to the fact that the program expenditures for physician services have grown faster than the index. Of course they have! The beneficiaries of this program, the aged and disabled, are the fastest growing segment of the population. Furthermore, they are availing themselves of the latest medical technology by using more intense services per beneficiary.

ELIMINATE DUPLICATE MEDICARE PAYMENT FOR SERVICE IN OUTPATIENT DEPARTMENTS

This proposal is directed towards eliminating so-called duplicate medicare payments for services in outpatient departments of hospitals. We are pleased that there is a differentiation made between the outpatient department and the emergency department. These differences are focused on several things: the emergency department is open 24 hours a day 7 days a week; all patients are seen who present regardless of their severity of illness of ability to pay; there is no scheduling of emergency department visits as one finds in an outpatient department; emergency departments are staffed and equipped to handle the most severe illnesses and injuries such as heart attacks, strokes and plane crashes.

In contrast, the hospital outpatient department can be viewed as a doctor's office except that it happens to be in a hospital. The hospital outpatient department is open certain hours and closed certain hours, schedules appointments, optimizes staffing patterns based upon known patient load and generally limits its practice, just as a doctor might do, to certain specialties and esoteric disease conditions.

DISALLOWED 2 PERCENT OF MEDICARE HOSPITAL COSTS

Probably the most important budget proposal is the disallowance of 2 percent of medicare hospital costs. This seems to be a fairly naked admission that the medicare program is just not going to pay part of its bill. Hospital costs won't go away. Primarily made up of wages, supplies, equipment and utilities, these costs continue to occur irrespective of other competing factors. Under this proposal, they would simply be passed on to the patients with the further prohibition that a hospital would be unable to pass on this 2 percent reduction to medicare beneficiaries. Where will these costs be allocated? In fact, they will be passed on to all other patients. To patients and employers who pay their health insurance premiums and to patients who pay their own bills. This is an indirect tax on other patients. If there is a disallowance of 2 percent this year, will it be 3 percent next year? 5 percent the following year? What will it be when I turn 65? There is no incentive for a hospital to put into effect an aggressive cost savings program because this proposal would penalize them for that achievement. The hospital that is economical and has no increase in its charges or costs from year to year would get the same reimbursement as the hosptial that realizes a 10 percent or 15 percent increase in its charges or costs. We think that it is unfair to legislate this indirect tax on other patients who will be forced to make up the difference through increased charges and increased health care insurance premiums.

CONCLUSIONS

As you deliberate the proposed changes in the system, we would like to offer three recommendations.

First, that you act not to shift costs to beneficiaries in such a way as to discourage them from seeking care on a timely basis. We believe that early detection and treatment of conditions is pivotal to the health care of the American public. It is particularly discouraging to know that an individual patient's illness might have been prevented or ameliorated if the patient had had access to a medical system that allowed for early diagnosis and treatment.

Two, please do not discourage more physicians from participating in the medicare program.

Three, we would suggest that an indirect tax on other patients by cost-shifting not occur under any legislative proposal. This cost-shifting has the sole effect of increasing health care costs on a universal basis.

Mr. Chairman and members of the committee, we thank you for the opportunity to present our views on the proposed budget cuts affecting the medicare program. At the same time, we extend an invitation to you and your staffs to utilize our knowledge and expertise as you move forward in addressing these critical issues.

Mr. **Anthony**. Three thirty-five. This is my first experience, by the way, at keeping time for the chairman.

I want to thank you for your testimony. I have a couple of inquiries. One, do you have any idea what the mix is between regular physicians and those physicians that accept assignment in hospital emergency departments as well as signing on to medicare?

Dr. **Sabatier**. I think among our colleagues in emergency medicine it is routine to accept assignment in both medicare and medicaid programs. I would say it is probably in excess of 90 percent, but I do not have exact figures. I do not personally know of any physicians who do not routinely accept assignment.

Mr. **Anthony**. We will accept the 90-percent figure. If in checking further after you leave the hearing today, you find that you can provide a more specific answer to that question, we would like to have it for the record.

Right now you are saying about 90 percent of the physicians would accept assignment in the hospital emergency departments?

Dr. **Sabatier**. Yes, sir.

Mr. **Anthony**. That figure would probably not be that high among other physicians, would it?

Dr. **Sabatier**. My impression is it is not, and it probably reflects the unique nature of our practice. We see patients who are generally unfamiliar to us, and this may be the only time that we see them. And in terms of rendering emergency health care, the care comes first and the payment is a secondary consideration.

Mr. **Anthony**. Would you like to respond?

Dr. **Cloud**. I believe Dr. Davis provided testimony earlier in the day that that figure was about 53 percent.

Mr. **Anthony**. Thank you.

I really enjoyed the little three-part summary that you made because it adequately leads, I think, into a question I had prepared that I wanted to ask you.

You are basically saying do not do something that will discourage the person from coming in and getting health care early on.

Dr. **Sabatier**. Yes, sir.

Mr. **Anthony**. You are also saying do not drive away the physicians or the hospitals by having reduction of payments. I assume here you are talking about the 80 percent instead of the 100 percent, and that cost shifting is a dishonest tactic. I will leave it up to the administration to address the third comment about whether it is a dishonest tactic.

The part I want to ask you about is No. 2, driving away physicians and hospitals, and primarily physicians. We did send Secretary Schweiker a letter. It came over the signature of the chairman of the committee, Rostenkowski, and we do have a written response back from him. I am going to quote from Secretary Schweiker, and then I will ask you a final question. This is concerning the lowering of the contribution.

> It should be noted that physicians are among the highest paid professionals in this country. The average income of physicians is about three and one-half times that of the average family's income. In addition, evidence demonstrates that in relation to other professionals, the rate of return to physicians from medical education is one of the highest. Small contributions by our country's medical professionals toward fighting the ravaging effects of spiraling inflation in our Nation are justified.

Question: Do you think that the physicians will contribute to the fight against inflation by accepting these assignments?

Dr. CLOUD. Mr. Chairman, the American Medical Association has clearly stated its belief that one of the most important goals for our country is the restoration of a sound fiscal policy that leads to a lasting economic recovery; and we have pledged to do our best and to shoulder our fair share of whatever burden is necessary to achieve that goal.

We have reiterated that policy, and we are reiterating that view today. And it is my belief that when we embark upon whatever program that we do that we will be able to provide the leadership to give positive assurance that there will be full cooperation by the physicians.

Dr. SABATIER. Mr. Chairman, in the way the question is phrased, from the Secretary's letter there seems to be an assumption that no contribution is being made right now, and I can assure you that there is a wide differential between the usual and customary charges and what the Government programs pay.

In addition, the bad debts and charity allowances, particularly in our specialty of emergency medicine, are quite substantial. So I guess my brief answer is I have already given at the office.

Mr. ANTHONY. What you are saying is that albeit doctors may be making large amounts of income based upon what the average income is in the United States, you are confident that they are doing their part at the present time.

Dr. SABATIER. Yes, sir. I feel that, for example, the 52 percent of physicians who routinely accept assignment of claims, each time they accept assignment they are giving a substantial discount to the medicare and medicaid patient.

Mr. ANTHONY. Let me just close with one comment. The last time the hospital cost containment bill came up I was one of those that helped sink Mr. Rangel's proposal because I thought it should be done on a voluntary basis. But just speaking as one Member of Congress, I have been embarrassed about my vote, and I have had difficulty going back into the fourth district town meetings and explaining the rationale behind a voluntary cost containment vote when the cost containment was not there.

I simply would say this. If you would like to continue to have the vote of at least one Member of Congress, either through voluntary efforts or some Government intervention, the cost containment is going to have to be there. And I daresay that you are going to have an awful lot of people taking the same viewpoint because of the ever-escalating cost of health—not only at hospitals. I can tell you that doctors are now being perceived in a very negative manner in some regards politically. I tell you that as a critical assessment of what I hear people saying, because that particular politic will also, I think, be involved and enmeshed in any decision that we make in the Congress.

And with that admonition I will yield to—I am sorry, would you like to respond to that?

Dr. RAINEY. Mr. Anthony, I would just like to say that I hope the physicians of America will not be totally blamed for a rather complex, difficult situation that we all face. In fairness to you, the substance of the AMA testimony, which was just presented by Dr.

Cloud prior to your arriving, was that the association feels that the time has come when perhaps we no longer should wrestle with band-aid approaches to the problems which are as major as we are faced with in these programs today; and that the American Medical Association would like to play the lead role in developing a new health policy with the input of people like you and members of this committee as well as other Members of Congress and the administration and other health professionals.

It is our feeling that the situation is so complex, and we find ourselves confronted with so many major problems that there is not one easy, simple solution with the situation as we have it now. And we certainly would welcome encouragement from your committee and others to proceed as we planned to proceed in an effort to develop a new policy which hopefully will provide a national health policy which would enable those in need to receive the need they deserve and not compromise quality nor access to care.

Mr. ANTHONY. I accept your statement. I think it is an accurate reflection of what needs to be done.

Let me say from a political standpoint that Members of Congress act as a lightning rod when there is unrest out in the masses. There is a lot of unrest about escalating health costs, and there are not but two other lightning rods there to be shared by us.

When a patient does go, they do see a doctor and they usually do go to a hospital. So when they do talk health care increases they have only two people to talk about, because they do not know the intricacies of the problem. Your advice is welcomed. We hope we can join in a partnership and solve this very complex problem.

With that I yield to Mr. Jacobs.

Chairman JACOBS. Thank you.

Dr. Cloud, you speak of long-range solutions, and I realize once a program gets going, to replace it with something else develops a problem faced by the Australian bushman who wanted to get a new boomerang but could not figure out how to throw away his old one. [Laughter.]

But do you think the country would have been better off if we had never passed the medicare program in the first place?

Dr. CLOUD. I would like to find somebody to yield to right now, Mr. Chairman. [Laughter.]

I believe, Mr. Chairman, that there are some aspects of the medicare program that we could have well done without. At the same time I believe that we have an obligation to assure that the people in this country who do need help, who do need care will be provided quality care and will be given full access to that care. And to the extent that a program provides that, and then I would—I am supportive of it.

To the extent that a program would offer opportunities for excesses and abuses and things that are away from the basic original goal of the program, then I think we would be better off without that aspect.

Chairman JACOBS. Do you think the program as originally conceived was a proper Government activity?

Dr. CLOUD. Well, Mr. Chairman, I think that portions of it have been beneficial and have done a good job, but I think that we have also seen from the outcome of some portions of the program that it has produced problems in cost and problems in delivery and accessibility and the invitation of excesses that are not desirable.

Chairman JACOBS. Doctor, what would you think of a cost containment program for the medicare part A and part B system that emulated the judgments of the prudent shopper. Uncle Sam would not contain the cost or say how much reimbursement there would be for medicare patients at a hospital, but simply would take the Hospital Association's guidelines for increased prices year by year and use a rule by which those hospitals which did not substantially comply with those guidelines would not have medicare contracts. In other words, if they charged any of their patients generally over the price, Uncle Sam, just as a prudent shopper—we are talking mainly about metropolitan hospitals, I think, whenever we talk about cost containment—just would not shop there. You just do not eat at the Rive Gauche when the taxpayers are paying for it.

What would you think of that?

Dr. CLOUD. Well, Mr. Chairman, I think that anytime you lay on an arbitrary kind of Government program, you have got to be certain that it does not impair the quality and availability or access to the care. I would be supportive of what you have outlined generally provided it does not lead to rationing and impairment of quality and availability. That is the byline—those are the underlying principles that we come from, and I would look favorably upon any program that would preserve those. But if it did not, then I would be quite distressed with that kind of program.

Chairman JACOBS. In other words, if you get a square meal in restaurant B, you would not have the Government deal with the Ritz or restaurant A that charged more for say the same square meal.

Dr. CLOUD. I would say that is correct.

Chairman JACOBS. Thank you very much. Thank you.

Mr. ANTHONY. The committee thanks you for your constructive contribution to the hearing today, and you are excused with that thanks.

Dr. CLOUD. Thank you very much, Mr. Chairman.

Chairman JACOBS. OK. The next panel scheduled is the Chamber of Commerce of the United States represented by Director Ozga; and the Washington Business Group on Health represented by Director Goldbeck.

STATEMENT OF JAN PETER OZGA, DIRECTOR OF HEALTH CARE, CHAMBER OF COMMERCE OF THE UNITED STATES

Mr. OZGA. Thank you, Mr. Chairman. I am Jan Ozga, director of the U.S. Chamber. I am pleased to comment on the administration's proposal to reform medicare in general and to have medicare become a secondary payer for the elderly.

We support that program. This position is based on the chamber's overall endorsement of the President's economic recovery program and the need for business to do its fair share in helping to implement this program.

Making medicare the secondary payer of claims will save the Federal Government and American taxpayers over $300 million in fiscal year 1983 alone and probably a great deal more over time since older persons consume health services two or three times more than younger persons.

We recognize that this savings will be made at the expense of the private sector, in particular, employers. However, the chamber has long held that health care programs for employees should be financed primarily by contributions from employers and employees. To make employer plans primary for older workers is consistent with this position.

There are a number of other provisions in the President's budget that are designed to save money in medicare, some of which involve more patient cost sharing which we support as a means of increasing consumer awareness about the true cost of health care.

We also support instilling more competition into the health care system and encouraging consumers to take better care of themselves. Policies and programs aimed at these objectives will improve the health and lower the cost of care for all Americans.

It is also necessary that improvements be made in how health care providers are paid for their services. Reducing how much medicare pays for services also results in other payers paying more. Thus, we are pleased to learn that this type of reform is an interim measure.

While we support reducing the size and cost of Federal programs such as medicare, we recognize the need to develop a more equitable payment arrangement for all payers. One such method is prospective payment in which charges are determined in advance and in which providers have the incentive to meet those financial targets.

This is only one of many recommendations being made by many business coalitions for health care around the country. Although they have different types of memberships and different agendas, all of these groups are committed to helping constrain the rising cost of health care in the areas in which they serve.

The chamber is proud to be assisting in this growth and development of these private sector initiatives to improve local health care systems.

Mr. Chairman, the rising cost of medicare is only one example of the larger problem of the rising cost of health care in general. The administration proposal to reform medicare is a first step in constraining the cost of this program and assuring that quality health care is available to older persons without raising taxes. At the same time, we recognize that overall changes need to be made in the way health care is financed and delivered so that more long term and more equitable reforms are instilled into our excellent, expensive health care system.

We also recognize the need to constrain the cost of government in general and to stimulate our slowly recovering economy; thus, we support the President's overall program to improve the economic health of our Nation. The administration's medicare reforms are part of the continuing move in that direction.

Thank you.

Chairman JACOBS. Thank you, sir.

[The prepared statement follows:]

STATEMENT OF THE CHAMBER OF COMMERCE OF THE UNITED STATES

Mr. Chairman, may name is Jan Peter Ozga. I am director of health care for the U.S. Chamber of Commerce and Committee Executive to the Chamber's Health Care Committee. I also serve as director of the National Clearinghouse on Business Coalitions for Health Action, a central source of information for some 60 such action groups located around the country.

I am pleased to be here today to speak to the issue of Medicare reform, in general, and medicare as a secondary payor of health claims for the working elderly, in particular. The U.S. Chamber supports this provision which would save money in medicare, even though we recognize that this proposal for employees aged 65 to 69 will cost employers about $300 million in additional benefits in its first year and possibly more over time, as experience leads to more claims and higher premiums.

Our support for the administration's medicare reforms is based on our overall general endorsement of the President's economic recovery program, with its emphasis on containing the cost of Government.

Both the progress of the past year, as well as the serious economic problems that remain, make it absolutely critical that the Nation continue on the course the President has charted. In particular, the U.S. Chamber strongly supports a new round of budget reductions to achieve the administration's goal of limiting Federal spending growth to at least 4.5. percent in fiscal year 1983. We totally reject the claim that Federal spending has already been cut as much as it can without adversely affecting those Americans who truly need assistance. We urge the Congress to enact as many program reductions as it takes to achieve the President's overall spending target and to exempt no area from scrutiny for waste, fraud, abuse and unnecessary spending.

U.S. CHAMBER AND HEALTH CARE

The U.S. Chamber is the Nation's largest business federation with over 225,000 members, including individual businesses, trade and professional association and State and local chambers of commerce. Among our business members, 85 percent employ 100 or fewer people, while 70 percent employ 50 or fewer. Clearly, the bulk of our membership is small employers. This group, incidentally, will be especially affected by making medicare a secondary payor of health bills for working persons aged 65-69.

It is the Chamber's position that everyone should have access to quality health care. Programs designed to achieve this goal should stress maximum private and minimum public involvement.

Such programs also should promote more competition within the health care industry, cost consciousness among providers and consumers, and individual responsibility for personal health among consumers.

Federal Government programs, such as medicare, are appropriate only when the private sector or state government is not able to fulfill an important health care need, and these programs should pay for the full cost of care so that public savings are not made at private sector expense.

The Chamber's intensive interest in health care began in the late 1960s, when our Economic Policy Department released a comprehensive study on trends in health care, including the early experience of medicare. The basic conclusion of this report was that the Government was going to become more involved in health care and that the cost of health care would continue to mount, and, most important to business, employers would continue to pay the lion's share of this cost.

In 1977, the health care industry formed a voluntary effort to contain rising hospital costs. For the first few years, the rate of hospital cost increases did decline, saving patients several billions of dollars. At the same time, the U.S. Chamber, through its affiliated National Chamber Foundation, sponsored an intensive study that documented the large investment business was making in American health care and why and how it should be more active in recommending and implementing ways to help solve rising health costs.

The result of this study is the Chamber's widely acclaimed health action program, which recommended a number of strategies that employers could use to: redesign health insurance plans to make them more cost effective; become more involved in establishing and supporting prepaid group practice plans, to instill more competition in health care; encourage employers to install health education programs in the workplace, so employees could learn how to take better care of themselves; and, educate business and community leaders to become more knowledgeable members of hospital boards and health planning agencies.

For more than three years we have been spreading this message throughout the country. I am pleased to report that people are listening and responding. A primary example is the creation of some 60 local business coalitions for health action that have adopted one or more of the strategies recommended in our health action program. Because of the growth and development of these groups and interest by other groups to help form such coalitions, the Chamber recently established a clearinghouse to serve this population and other interested parties.

The interest among businesses in health care is underscored by the fact that business is the largest private purchaser of health services in the country. We estimate that in 1982, business will spend over $70 billion just on premiums for group health insurance, and perhaps an equal amount on other health related items, not the least of which are taxes to support medicare.

MEDICARE: SECONDARY PAYOR FOR WORKING ELDERLY

Medicare, title XVIII of the Social Security Act, was implemented in 1966. In its first year, it cost about $3 billion. Although this seems to be a mere pittance compared to today's health care cost, even this expenditure was a great deal more than medicare advocates predicted.

Today, medicare has grown into a $45 billion program serving not only persons 65 years of age and older but, in some cases, certain disabled persons, for a total beneficiary population of nearly 30 million. An estimated 500,000 of these are workers aged 65-69, according to the U.S. Department of Labor.

The financing of health services for employees and their families should be primarily by employer and employee contributions. This conviction, coupled with the Chamber's support for the administration's basic economic goals, allows us to endorse the measure to have employer-paid insurance be the first payor of claims for working persons aged 65-69, with medicare becoming the secondary or supplemental program.

According to several estimates, this reversal of current health care liability should cost employers an additional $300 million, which will affect small businesses and/or self employed workers the most. However, the Chamber and bulk of its members recognize that business must do its fair share in helping to reduce the size of Federal Government and revitalize the economy. This medicare reform is one way that business can contribute to this laudable goal.

We realize, of course, that this $300 million employer cost could increase quickly as older workers, who consume health services at two to three times the rate of younger persons, cause an employer's claims experience and subsequent premiums to rise.

Naturally, we are concerned that this provision will continue the trend by government to save money on public health programs at the expense of the private sector. This can occur in ways that are not always so obvious and which are most acute in payments for health care services.

For example, a recent publication by the Health Insurance Association of America reported that, because of reimbursement cuts by medicare and medicaid, almost $5 billion in 1981 were passed on to other patients, those insured by commercial plans and those paying directly out of pocket. Medicare cost saving recommendations in the President's budget could have the same result. With this in mind, our positions on other selected medicare reform provisions in the administration's budget follow.

INDEXING MEDICARE PART B DEDUCTIBLE

An estimated $65 million would be saved in fiscal year 1983 if the supplemental medical insurance (part B) of medicare were indexed to the Consumer Price Index in order to keep its economic value constant. This deductible, which acts partly as a deterrent to over-utilization, is now $75 per person per year. The Chamber supports this cost saving provision of the budget.

ELIGIBILITY TO START DURING FIRST FULL MONTH AFTER AGE 65

An estimated $145 million would be saved in fiscal year 1983 if this provision were enacted. The Chamber supports this and similar changes proposed for other entitlement programs.

ESTABLISH PART A ENTITLEMENT COVERAGE FOR FEDERAL WORKERS

The Chamber has long called for universal coverage by Social Security. This provision would be a first step in that direction. By bringing federal employees into Medicare's Hospital Insurance (HI) (Part A), the program would realize a $619 million revenue increase in 1983. It is vital that this provision be enacted, since HI Trust Fund expenditures will exceed income in 1985 and will be exhausted by the early 1990's.

INSTITUTE CO-PAYMENTS FOR HOME HEALTH SERVICES

Another cost-saving feature of the budget which we support, this proposal is also designed to reduce over-utilization by imposing a 5 percent co-payment for the first 100 home health visits and 20 percent co-payment thereafter. Medicare would save about $35 million in fiscal year 1983 under this change. Left unchecked, this service—which is growing at an annual rate of 30 percent—would accelerate the depletion of the HI trust fund.

REDUCE RATE OF INCREASE OF HOSPITAL REIMBURSEMENT BY 2 PERCENT

A savings of $653 million is projected for fiscal year 1983 if this provision were enacted. It is designed to offset hospital increases that average 20 percent nationwide, well over double the general rate of inflation for 1981. However, many hospitals are already complaining that medicare is paying for only about 60 percent of their costs, "requiring" them to pass on these "losses" to other payors. In 1981 this shortfall amounted to nearly $5 billion. Accordingly, such savings amount to cost shifting. Clearly, more systemic changes need to be instituted to result in real overall savings. One such method is prospective payments in which charges are established between providers and payors in advance. Hospitals then have the incentive to meet those targets, realizing the savings if they come under the target and being at risk if they are over. Such a payment system would be consistent with the administration's plans to develop a more competitive health care system as well as its proposed payment system for renal dialyses provided to medicare beneficiaries.

ELIMINATE FEDERALLY FUNDED PSRO'S

A program which promised to save money in medicare are the professional standards review organizations (PSRO's), physician peer review groups that monitor and evaluate the hospital care of medicare and other public health patients. Nearly 200 PSRO's have been operating at various levels of effectiveness for nearly 10 years. Yet, every independent assessment of these programs reveals that PSRO's are spending more than they are saving. And, in some cases, savings have been made at the expense of the private sector.

Yet, about 15 percent of the PSRO's have achieved a positive cost-benefit record. For this reason, private industry has contracted with about 25 PSRO's to conduct private review on 50 private patient populations.

As we testified last year, we support the phase out of Federal funds for PSRO's, which will save the Government $76 million is fiscal year 1983 outlays. However, consistent with our earlier recommendations, we are pleased to learn the Senator David Durenberger and others are considering introducing legislation to help create private peer review groups that would contract with the Federal Government or any other interested organization for their services. Certainly, a watchdog is needed on the care provided to elderly and poor patients, so as to eliminate fraud, abuse and waste. Private PSRO's, under a contractual arrangement—not Government subsidy—hold the promise to provide this necessary service.

CONCLUSION

Health care is big business. The national health care bill is $300 billion annually. Employers pay about one half this amount through private health insurance, taxes to support medicare and medicaid and other health-related items. Medicare has played a large part in the rise of hospital and health care services, paying for 26 percent of overall hospital costs and 17 percent of total physician services. Under current law and policy, the program is projected to grow about 16 percent or about $8 billion in fical year 1983, compared to an overall budget growth of 4.5 percent. The continued aging of our population means that additional strains will be placed on our health care system, including its ability to pay for these services. Steps need to be taken now to assure the availability of quality health to older Americans.

The administration's budget projects a 1983 savings of nearly $3 billion in medicare, a figure that will rise to over $16 billion by 1987. However, even with the proposed changes, medicare benefits would increase by 10 percent in 1983 and payments to doctors and hospitals by 12 percent. Thus, we are talking about decreasing medicare increases, not actual cuts in the program, as some of the administration's critics have contended.

The Chamber supports these initial attempts to curb medicare's spiraling costs. The administration's proposals, by preserving trust fund assets, will help assure that basic benefits can continue to be paid in the future without tax increases. These proposals require all participants in the health care system to make certain sacrifices and reorient some of their health care practices. Part of the sacrifice is shifting some costs to the private sector, as with the working elderly. However, we continue to be concerned about additional hidden cost shifting to the private sector by having medicare pay less than its fair share. Containing rising costs in both private and public health programs presents a major challenge. But the job must begin now if we are to maintain an essentially private health care system at affordable cost.

Chairman JACOBS. Mr. Goldbeck.

STATEMENT OF WILLIS B. GOLDBECK, EXECUTIVE DIRECTOR, WASHINGTON BUSINESS GROUP ON HEALTH

Mr. GOLDBECK. Mr. Chairman, Mr. Anthony, my name is Willis Goldbeck, executive director of the Washington Business Group on Health. I will cover four points.

Let me preface my remarks by noting that the entire medicare reform issue must be seen as just one manifestation of the broader challenge to the values and priorities inherent in the reduction of governmental commitments to the poor and the realinement of responsibility for social services.

The first issue is the medicare shift to becoming secondary payer. There simply is not a single business position on this issue, much as one might be desirable.

Nearly everyone understands and conceptually can support the logic of treating all active employees equally. Many will accept this challenge. Nonetheless, many are opposed to the shift in primacy because they are unwilling to voluntarily accept the direct cost, the double payment, the open-ended commitment, and the disparity of impact.

I would further note that many responsible employers are concerned about the negative impact on the hiring or retention of the elderly. Also, there is absolutely no indication what the real savings or cost of shifting from such a provision would be. There is no tabulation of how many people are in this category or what the health experience is for groups of 65- to 69-year-olds with anywhere near enough of a volume to be able to tell what the cost will be over the next several years.

The second point is there is absolutely no justification for ending the utilization review requirement for medicare or eliminating the PSRO program at this time. To do so is not to help the private sector by deregulation, as was stated this morning, but rather to hurt all sectors by encouraging further waste and abuse. Until Congress replaces the PSRO program with a better mechanism, we urge you not to replace it with a void which will all too quickly be filled with unnecessary costs.

With each passing year we have stronger evidence of the values of utilization review by PSRO's for private sector payers. How ironic that this evidence is greeted by continued pressures to stop these programs for the Nation's largest payer.

The administration says it wants to do away with ineffective PSROs, but the only ones left are those that passed their own effectiveness test only last year. Maybe some day we will have a system so imbued with true competition, managed with such integrity, and used by patients so knowledgeable that utilization review will die from a lack of need. That is not this year.

The third item is cost shifting, and we reject the contention, as have others, that cost shifting to another payer or unilaterally paying less than legitimate cost is actually a cost savings. Cost shifting is nothing less than tax increasing. Prudent management is not the issue, not because savings cannot be found, but because there is absolutely no inducement or reward for doing so.

I reject, for our organization, the 2 percent proposal. As one who has participated in both the voluntary effort and coalition movements, I object to the idea that these be saddled with a commitment that they never undertook. None of them have volunteered to accept the cost shifting, and none of them have volunteered to solve the medicare problem.

Further, I find it curious that the administration which says they do not anticipate any cost shifting, finds it necessary to take the extraordinary step of prohibiting cost shifting to their other programs. Ultimately, cost shifting comes from our individual pockets, whether through reduced compensation, increased cost sharing, or simply larger out-of-pocket payments.

We are not saving by this shift from Government. We are the ones that provided the Government revenues in the first place.

Finally, systems reform. None of the proposed medicare reforms will have any lasting significant impact on total health care costs, demand or supply. We need a totally new comprehensive assessment of who will need what kind of public assistance for health care in the year 1990.

If we are unwilling to make this investment in the degree of analysis and public constituency building, we will arrive at 1990 still tinkering with a medicare or medicaid program that is already deemed inadequate and inappropriate. We will do so in the face of economic and demographic imperatives which should compel us to act now.

We need to replace the UCR system. We need to recognize that the only meaningful financial reforms are those which involve all payers. We need to use the aggregate purchasing power of the Federal investment to create price competition. We need that prospective reimbursement system that has been talked about over and over again.

In closing, we need to make the budgetary commitments that would match the administration's rhetoric that prevention is the key to health status improvement. The rhetoric is correct. Only the budget is wrong.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF WILLIS B. GOLDBECK, EXECUTIVE DIRECTOR, WASHINGTON BUSINESS GROUP ON HEALTH

HIGHLIGHTS OF TESTIMONY ON FISCAL YEAR 1983 MEDICARE BUDGET

1. Private employers have the same interests as the government in effective health care cost management.
2. Many of the medicare budget proposals will not achieve real savings, only a shifting of costs to other payers.
3. The budget rhetoric in support of prevention is contradicted by the budget allocations.
4. While some of the cost shifting is an acceptable realignment of social responsibility, we oppose the basic thrust and note that the resultant disparity in reimbursement levels among different payers in the system acts as a deterrent to our mutual goal of increasing price competition.
5. No unified business opinion exists concerning the proposal to make private health insurance the primary payer for workers aged 65-69. We feel it is more important to acknowledge this lack of consensus than to pretend agreement exists where in fact it does not.
6. We oppose the elimination of the utilization review requirement for medicare. We oppose the elimination of PSRO's We urge your support for a new PSRO program along the lines proposed by Senator Durenberger.
7. We recommend the establishment of a prospective hospital reimbursement system for medicare.
8. We recommend the encouragement of greater medicare beneficiary enrollment in HMO's.

Through taxes, private sector employers and employees pay for the medicare program so we are appreciative of this opportunity to give you our views on some of the administration's fiscal year 1983 medicare budget proposals.

Additionally, the 200 member companies of the Washington Business Group on Health provide health care benefits for some 55,000,000 employees, retirees, and dependents. These programs spend hundreds of millions of dollars annually on coverages that supplement medicare. This fact, combined with the increasing number of employees electing to work beyond age 65 and overall health insurance cost increases of unprecedented proportions make our members just as concerned as you are about medicare program improvements.

There are many aspects of the budget and past year's work by the Department of Health and Human Services that are deserving of praise: reduction of wasteful regulations and paperwork; increased efforts to capture revenues owed the Government; improved program efficiency; increased appreciation for the value of prevention; starting to grapple with the difficult rationing decisions that are inherent in the commitment to reduced Federal responsibilities.

All of these efforts are appreciated by our members as they too seek to reduce waste in the health care system.

The budget also contains two themes that we find damaging to our mutual goal of a health care system that serves all Americans in a cost efficient manner.

A. There is little point in claiming that "prevention activities have been identified as the most promising area for future improvement in the health status of the Nation," while not only refusing to allocate a commensurate portion of the budget to meet this promise but also reducing funding in real dollars for such proven programs as child immunization and the Office of Smoking and Health. This Administration and the Congress have the opportunity to earn their place in history as the first to support the rhetroic of prevention with the reality of a sound investment in the future health of all Americans.

B. Equating cost shifting with cost saving fails to recognize that solutions to our health care cost problems will have to be system-wide in order to be truly effective. Shifting the cost from Government to those who pay for Government anyway will ultimately constitute true savings only when the entire system is made considerable more efficient.

Congress should also recognize that cost shifting, or more accurately, the actions of any major purchaser to arbitrarily set reimbursement at levels below cost constitutes a barrier to the establishment of real price competition, an objective all purchasers should support.

Our positions on the specfic budget proposals, issues for futher discussion, and recommendations follow.

SUPPORT

1. Bringing Federal employees under medicare part A.

2. Begin medicare coverage on the first day of the month following the month in which age 65 is achieved.

Note: The budget statement implies that this change will not cause a gap in insurance coverage since people will be able to retain employment based insurance. We urge caution since many people become medicare eligible when they are not working for an employer who provides that kind of extended health care insurance.

We also note that the projected $131 million savings is actually just another example of cost shifting to the employers and employees.

3. Update part B fee screen to October 1.

4. Reimburse inpatient radiology and pathology services at 80 percent of reasonable charges.

5. Eliminate duplicate medicare payments for services in outpatient departments.

6. Eliminate medicare subsidy for private rooms.

Note: The premise that this will cost the hospital money rather than the beneficiary is yet another example of the failure to understand—or acknowledge—that hospitals will increase charges to other payers rather than reduce their own budgets.

7. Set a single medicare reimbursement limit for hospital-based and free standing facilities.

Note: The proposed exemption process would significantly reduce the projected savings.

8. Administrative cost savings.

Note: The issue is not the number of employees taken off the role, but rather the impact this has on the functions they were to perform. We would caution against reducing HCFA's capacity to collect and analyze the data that is the ultimate basis for the program authorization and appropriation decisions that you, the Congress, will have to make and defend to the public.

OPPOSE

1. Elimination of the PSRO program.

We reaffirm our support for the requirement for utilization review in medicare and for the PSRO program. For the past 2 years we have provided Congress with case examples of the positive results achieved by private employers as a result of their contracts with PSRO's savings that could also be achieved by the Federal Government if it wished to do so.

Last year, the administration made a commendable effort to eliminate those PSRO's considered to be less effective. Congress provided funding for the continuation of only those PSRO's that the administration claimed its own analysis had proven to be cost effective. Therefore, if Congress were to accept the current budget proposal, you would be eliminating the very PSRO's in which you made an investment last year based upon that determination of effectiveness.

In addition, we call to your attention that last year, the administration's justification for ending the PSRO program was that it would no longer be needed due to the administration competition program. Today, that program has not even arrived as a proposal, much less become law or produced the system's alterations that might someday justify an end to the PSRO program.

We urge the Congress to look carefully and with favor upon the new PSRO legislation proposed by Senators Durenberger, Heinz, and Moynihan. Their concept recognizes the appropriateness of a sustained Federal Government responsibility for utilization review; recognizes that we should and can learn from the past PSRO experience rather than simply wasting all that public investment; recognizes the growth of private sector UR programs; and establishes an incentive, performance-based PSRO system that meets the quality and cost management goals we strongly support for a truly effective private-public partnership in the health care delivery system. We will be working with the Senate Finance Committee on the details of this legislative proposal.

2. Disallowance of 2 percent of medicare hospital costs.

While we are certainly supportive of real progress in the hospital cost control effort, we reject the contention that this proposal will result in real savings. Federal savings are not health care cost reductions unless compensating charges to other payers are prohibited. To expect the hospitals not to shift the costs is to deny that they will—and must—behave as rational economic entities.

A SPECIAL ISSUE: MEDICARE AND THE WORKING ELDERLY

My task would be a lot easier if I could tell you there was unified support for, or opposition to, the working elderly proposal. It would be easier but it would also be very misleading.

During the past year, through surveys, interviews, task forces, seminars, and countless small group discussions with our own members and other large employers, we have consistently found business leaders to be divided on this issue. To report anything else to you today would be a disservice to the integrity of your hearing.

We believe many employers are ready to accept the compelling logic of providing all active employees with the same health care benefits regardless of age. Certianly, the proposal recognizes that for years, private employers have claimed to have a level of benefit management efficiency greater than that achieved by Government. Given this history, the fact that employers and employees pay for medicare one way or another anyway, and the companies' desire to assist the President in reducing nonessential Federal activities, many are supportive of this proposal.

Others, however, remain opposed. They point with concern to a potentially negative impact upon the employment of the elderly. They see the demographic trend which clearly show the small cost today will be a very large cost in the years ahead. They question the inequity of having older workers continuing to be taxed for a benefit they will no longer be eligible to receive. And, many are concerned that this measure will be extended to retirees.

We call to your attention the very great disparity of impact this proposal would have on different employers. Many companies actually have no workers in this age category. Retail firms on the other hand are a primary employer of the olderly and would experience major cost increases at the very time when they are having other economic difficulties. Ironically, the employers who have done the most to meet the Nation's objectives in hiring the elderly would be the employers to suffer the greatest cost increases.

Although our group works only with very large companies, we note that small firms would have a much harder time adjusting to the proposed change since they have far fewer employees across whom to spread the increased compensation costs.

In summary, what you hear from business is a rather accurate reflection of the different ways the proposal would affect different companies.

If Congress moves ahead with this measure, we urge you to make it applicable to those other employers in the Government and not-for-profit sectors who participate in medicare benefits.

If Congress moves ahead with this measure, we will do everything we can to make it work for the protection of the elderly and the reduction of unnecessary health care expenditures.

Finally, if implemented, this transfer of responsibility should assure that the elderly do not suffer from unintended discriminatory employment practices. Providing increased quantity and quality of working opportunities for the elderly is a higher priority for the nation than simply shifting the cost of health care from one payer to another.

ISSUES FOR FURTHER DISCUSSION

1. Coinsurance for Home Health Services.

The Nation needs an increase in high quality, well managed home health services. At the same time, we do want to avoid unnecessary utilization of all medical services, including those delivered at home. Our position is to encourage reimbursement system designs that remove any economic incentives for inapporpriate hospitalization.

Since there is no significant experience that would enable us to realistically project the impact of the proposed regulation, we urge you to fund a demonstration program of sufficient scale to provide conclusive guidance for the final program design.

2. Utilization management requirement for medicare contractors.

In principle, we applaud any revision that would result in waste reduction. However, we cannot support a budget proposal which is based upon a program and implementation strategy which the administration acknowledges will not be ready until 1983.

Further, it is hard to understand how this undefined effort can be justified based on its claim to parallel and supplement a similar effort in the private sector. The private sector effort referred to is an informal, albeit highly worthwhile, effort to encourage local cost management programs. Utilization review is one recommended activity, however, there is no action program for the hypothetical federal program to parallel.

We will be happy to work with the administration in the development of its program, and in assuring coordination between its program and those efforts that are emerging in the private sector.

RECOMMENDATIONS

1. Medicare prospective hospital reimbursement.

We had expected the administration to propose significant medicare restructuring through the establishment of a prospective hospital reimbursement system.

In the absence of an administration initiative, we hope the Congress will add such a requirement in the course of the budget deliberations.

2. Medicare reimbursement for HMO's.

We urge Congress to approve medicare reimbursement for HMO's at 95 percent of medicare's adjusted average per capita cost.

3. Medicare restructuring.

Major employers and unions, without any legislative mandate, are increasing their efforts to stimulate competition among providers by offering multiple choice and flexible benefits plans; developing data systems that compare provider performance by price and quality; and employee information systems that give knowledge and incentives for the most cost effective use of health benefits.

We believe the Government could make a further contribution towards a more competitive system by restructuring the medicare system through the provision of a stop-loss benefit balanced by appropriate front-end coinsurance and seeking opportunities for voucher experimentation.

CONCLUSION

We are a Nation struggling with realignments in the division of social responsibilities among levels of Government and between the public and private sectors.

What we do with the medicare budget is one reflection of this larger, complex value struggle. We share your concern for cost and want to close by assuring you of our support for a continued commitment to the basic and essential value, in this still marvelously affluent land, of access to quality health care for all in need.

Chairman JACOBS. Thank you, Mr. Goldbeck.

Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

Is it Mr. Ozga; is that correct?

Mr. OZGA. Yes.

Mr. ANTHONY. I would like to ask you a few questions on your summary sheet.

You support the President's overall goal of trying to reduce the growth of Federal spending to the 4.5 percent in fiscal year 1983, as I understand it.

Mr. OZGA. Yes.

Mr. ANTHONY. Have you had an opportunity to examine the makeup of where that 4.5 percent is derived to ascertain whether or not there are any equitable fairness problems with it?

Mr. OZGA. Well, they come from multiple sources, and I guess the larger part of that obviously has to do with domestic programs. Clarify your question, if you will.

Mr. ANTHONY. What I would like to know from you, representing the chamber, is if you think it is fair for the administration to achieve a 4.5 percent overall goal by taking programs that represent over 60 percent of the budget and undergo most of the cuts, while portions of the budget that represent much less percentagewise sustain much less. Yet when you average them out you come to the 4.5 percent.

I just wonder if you see any fairness arguments there? Are you satisfied that it is a fair and equitable distribution?

Mr. Ozga. We had a large discussion on this issue, and this was the consensus of our board, yes.

Mr. Anthony. That it was fair?

Mr. Ozga. Yes.

Mr. Anthony. The Washington Business Group, is that comprised of business people?

Mr. Goldbeck. Yes, sir; that is approximately 200 very large corporations, if you will colloquially, your Fortune 500-size corporations.

Mr. Anthony. Fortune 500, and they are dues-paying members of the national chamber of commerce?

Mr. Goldbeck. Yes, sir.

Mr. Anthony. Did they have an opportunity to have their input into the national chamber board's discussion and decision—because what you are saying, and what the chamber is saying does not fly together. You are on two different tracks.

Mr. Goldbeck. That is correct, and I felt very strongly after rather considerable review and meetings all over the country that there was no evidence that the larger employers were unified on this issue; I felt it would be irresponsible for me to come in here and pretend they were when, in fact, I could not produce that unanimity of opinion.

Mr. Anthony. What about you, Mr. Ozga? Do you agree with that? Are you saying that the chamber is not speaking for the unified voice nationwide on this proposal?

Mr. Ozga. Our board spoke with a unified voice, yes.

Mr. Anthony. I am talking about your membership. You have a gentleman here that represents 200 that he says make up the Fortune 500. I can tell you that I've gone back to my district, and if I had to read the two statements at a public meeting and ask for a show of hands, I can tell you that Mr. Goldbeck is going to beat you pretty bad.

Now, I cannot tell you nationwide, but I have small business people, and I have large business people that are calling me and writing me. I must admit that they are agreeing much more with what Mr. Goldbeck is saying than what you are saying. I guess I am a little bit confused. Two business groups sitting side by side, looking at the same budget proposition and basically taking two different tracks, and asking this committee then to sort through it and make a decision.

Mr. Ozga. Well, one, you must keep in mind that we represent a larger constituency. Medium and small businesses are also a part of our membership, and I guess that approaches about 200,000 at this point. And in many respects the decisions that we made as a board represent a position to support the President's overall budget, recognizing there be some sacrifices made individually, and in particular in this medicare as a secondary payer.

Mr. Anthony. Let me just go one step further then. In another paragraph, or another sentence in that first paragraph, you say that no area should be exempt from scrutiny for waste, fraud, abuse and unnecessary spending. Are you including defense in any of that?

Mr. OZGA. Yes.

Mr. ANTHONY. In what area? For waste, fraud and abuse?

Mr. OZGA. All three if they exist, yes.

Mr. ANTHONY. The unnecessary spending?

Mr. OZGA. Yes.

Mr. ANTHONY. If we can find some waste, fraud, abuse, and unnecessary spending in defense, the chamber is going to support the Congress efforts to curtail that expenditure?

Mr. OZGA. I assume it will, yes.

Mr. ANTHONY. Has your board taken a position on that?

Mr. OZGA. That is the position you have just read.

Mr. ANTHONY. But it does not use the word "defense," and I am just a little bit—I am not trying to be picky, but I am really just trying to find out where the business community is coming from. I guess what bothers me the most about one speech or one testimony yet what seems to ring very clear as being a very accurate portrayal of what is going to happen, is the 2-percent cost shift. Your statement is everybody needs to make sacrifices to improve our economy; yet Mr. Goldbeck is saying that all we are going to do is shift the cost; we are not going to do anything to hold the cost down.

Basically what the chamber is saying is let's spread the burden, but where is the incentive to reduce the ever-escalating cost of health care? Just shifting the burden and making more people take part of the load is not going to bring the forces to bear to bring the cost down. At least that is what bothers me.

Mr. OZGA. In our oral statement and written statement we acknowledge the fact that this is an interim measure and does not get to the heart of the problem which is reimbursement. I think the unanimity of opinion among most people today, including us, is that prospective payment approach is something that goes a long way toward getting something close to an equitable payment system.

Mr. ANTHONY. Just a final comment. Going back to what the doctors immediately before you testified, they indicated it was a very complex problem, and that maybe some major revisions and overhaul needed to be done. If you agree with that, would your two groups be willing to work with the Congress to try to find the proper mix so that we could have some cost containment in the health area?

Mr. OZGA. Absolutely.

Mr. GOLDBECK. Completely, and in fact, that is why I included in my oral statement the comment at the end that medicare and medicaid, the governmental commitment to the provision of health care for any segment of the population needs a basic review. In the meantime, however, I do not think we can ignore the realities of the budget reductions which are taking place. Even the purported increases are, in terms of inflation and other factors, actually decreases in many cases. I do not think we can ignore those and pretend they are going to go away while we are being more visionary, which, in fact, we ought to be. So, I think we have to move on two tracks simultaneously.

I might make one additional comment on this cost shifting point. Cost shifting is a nice catch phrase. There are different categories.

For instance, some of the administration's proposals are, in effect, management improvements in a particular program. If done well they may result in the Federal Government spending less because it is actually performing in a more efficient fashion. That, in turn, leads to cost shifting if the private sector does not meet its responsibilities to do likewise. That is an acceptable kind of cost shifting.

On the other hand, a mere reduction of commitments and the pretension that that is in fact a savings is a very different kind of cost shifting. The latter is much more objectionable.

Mr. **Anthony**. What do both of you think employers could do or would do as part of an effort to help reduce the cost of hospital care? You do not want to do away with PSRO's. Your business colleague to your right, he wants to get rid of PSRO's.

Mr. **Ozga**. Federally funded PSRO's, sir.

Mr. **Anthony**. All right. Let's say we had a mesh of private initiatives and other initiatives. What would your private sector do? What would you suggest that they do to try to help hold down the cost?

Mr. **Goldbeck**. There is a rather large range of things. If you want to start with the PSRO issue, we have been working very closely with Senator Durenberger and his staff. They have a proposal to adapt the PSRO program to a less regulatory approach while continuing to have Federal involvement in the process.

Our particular point is that you do not want to simply remove the largest payer in the entire Nation from a process that is proving itself to be increasingly effective and doing so by and large on the basis of a Federal investment. It seems to be a rather poor way to reject what we have learned from that investment.

I think there are a great many other things. You do see some emerging from the coalition types of activities, but it would be foolish at this stage of the game with most of them less than 2 years old, to pretend that they are going to be the next salvation. There are no salvations, sir. There is only a long, drawn out, difficult process, and there are not going to be any quick fixes to which we can turn now or prior to 1984. Success is certainly not going to happen out of one particular kind of local group any more than it did out of a voluntary effort or any governmentally imposed singular approach. We must have a strategic, multifaceted, and multiyear approach.

Mr. **Anthony**. Any final comments you want to make, Mr. Ozga?

Mr. **Ozga**. Yes, there are some things that the coalitions have common in terms of steps that they are taking that I think can improve health care for all Americans. First of all, a whole redesigning of benefits where we get people out of the hospital when this is not needed so they're served in some other setting. Also promoting competition among various types of health providers.

The whole wellness movement is one that the coalitions are very supportive of and one that WBGH is very much involved with; helping people take better care of themselves.

Finally, and maybe this is where we can get some real leverage, is the whole notion of educating hospital trustees as to making the kind of decisions in that boardroom like the kind of decisions that are made in the corporate boardroom, putting some business sense into how a hospital is run and highlighting the issue that we have heard all throughout the day, this cost shifting arrangement. This is causing the trustees to say, "Wait a minute. This is coming back to hit me. What can we do to make the system a little bit more equitable?" That is the kind of private-sector leverage or pressure I think that is probably going to be most effective on the physician or the hospital, not just some sort of government regulation.

Mr. ANTHONY. Thank you very much.

Chairman JACOBS. Mr. Rangel.

Mr. RANGEL. I have no questions.

Chairman JACOBS. I have one question of Mr. Ozga.

What effect would the second pay status of medicare have on the hiring of senior citizens, 65 to 69 years of age? Do you have an opinion on that?

Mr. OZGA. I think it depends on the kind of business that we are talking about and the kind of health benefits that are already being provided. I think it is fair to say that it would cause some employers to question the type of employee he would put on as experience grows in this area.

I am not prepared to say exactly what the response would be.

Chairman JACOBS. Mr. Goldbeck, do you have an opinion?

Mr. GOLDBECK. Yes, I think Jan is absolutely right. There is not going to be a uniform response across all of industry, even within big businesses. For instance, retail has far more elderly workers and part-time elderly workers than does almost any other sector of employment. Their considerations have to be very different than a company which has four or five people who remain in that work category, in that age category.

On the other hand, the smaller businesses are faced with a different kind of problem. Even though the numbers of people retained, 65 to 69, may be small, the increased cost has a smaller base across which to be spread. There are fewer employees, fewer products sold and so forth, so there I think you would almost inevitably see a greater questioning. As one of the earlier witnesses pointed out, we have hardly solved our employment-of-the-elderly problems in the United States. Every new impediment makes it that much more difficult.

Chairman JACOBS. Who has more employees, big business or little business?

Mr. GOLDBECK. Little business by far.

Chairman JACOBS. That is what I thought.

I thank the panel very much for its contribution to the record, and we will retain it on the record.

[The following was subsequently received:]

WASHINGTON BUSINESS GROUP ON HEALTH,
Washington, D.C., March 12, 1982.

Mr. JOHN S. SALMON,
Chief Counsel, Committee on Ways and Means, Washington, D.C.

DEAR JOHN: During the March hearing on the medicare budget, Congressmen Jacobs and Anthony expressed interest in: First, what can be done to control escalating health care costs; and second, what employers are doing now.

The questions were too broad and the time too short for a comprehensive reply during the hearing.

To be sure, there is no simple or brief answer to this problem. However, I did want to be as responsive as possible and so we've prepared two brief papers which may be helpful at least as an introduction.

The first is A Review of Employer Health Care Cost Management Efforts. While far from a complete directory, this will give the Members a very quick view of trends and leaders.

Second, I've enclosed An Approach to Health Care Cost Management, which is an attempt to place the range of public and private efforts in a broader policy concept.

Finally, enclosed is a copy of the new health paper issued by the Business Roundtable [retained in subcommittee file].

You may use any of these items either in the record or separately for the staff and Members. Do call if there are any other ways we can work with you on these issues.

Best wishes,

WILLIS B. GOLDBECK,
Executive Director.

Enclosure.

MEMORANDUM

To: Ways and Means Health Subcommittee
From: Willis B. Goldbeck
Re: A Review of Employer Health Care Cost Management Efforts

Trends in corporate cost management efforts can be sorted into two primary categories: action programs at the local level; and in-house policy and program developments. Evidence resulting from the efforts of those companies that have become leaders in one or both of these categories establish that such efforts are sound business practice and should be emulated by other employers in both the public and private sectors.

Examples of employer's efforts in each category and a listing of proven targets of opportunity for employer leadership are provided in this brief paper.

LOCAL ACTION PROGRAM GROUPS

Successes in this category run the gammit from participation by corporate officers on the boards of health planning agencies to the establishment of independent purchaser coalitions; from sponsorship of wellness events to the development of community health facilities; from contracting with a PSRO for utilization review to the creation of a new HMO.

PLANNING

While the record of health planning agencies is uneven, Goodyear has calculated that its participation with the HSA in Akron, for which a Goodyear employee became the President, saved the company several million dollars each year.

COALITIONS

During the past 24 months, business leaders have been developing local coalitions that are comprised of either purchasers only or a mix of purchasers and representatives of the providers. Many of these are too new to have a measurable impact on health care costs, however, they are viewed as the most fundamental organizational step from which a wide variety of cost management activities can be launched. Leading examples include: TRW, in Cleveland; AT&T, in Fairfield-Westchester County, Rochester and New York City; Alcoa, in Pittsburgh (US Steel, Westinghouse, Dravo, Jones & Laughlin, and Morgan Bank are also on the steering committee); GE, in Philadelphia and Louisville; Deere, Caterpillar, and others in the Midwest Business Group (which the WBGH started); Federated Department Stores, United Technologies, and Eastern Airlines in Miami.

Several companies are in many coalitions and are in the process of establishing new groups at this time: IBM, Burlington Industries, Standard Oil of California, Owens-Illinois, and Citicorp are a few examples.

Finally, other organizations such as The Business Roundtable, AMA, HIAA, local hospital councils, local Chambers of Commerce, and health planning agencies are all working to establish/stimulate coalitions.

WELLNESS

Campbell Soup's health fair and Citicorp's "fun runs" are examples of employer leadership in extending the wellness effort beyond the benefit package. Wellness programs are the fastest growing employee benefit and are proving to be very cost effective.

Other companies, such as IBM, have based their entire wellness effort around the development of community health facilities such as the YMCA's.

PSRO'S

In testimony before Congress, Caterpillar, Deere, and Motorola presented evidence of the substantial return-on-investment they had received as a result of their contractual utilization review programs.

HMO

WBGH members have taken the lead in the development of HMOs in communities where none existed or where physician opposition was too great for an HMO to develop without strong commitments from the Chairmen of major local employers. Examples include: Ford and GM in Detroit; Deere, Caterpillar, and International Harvester in Des Moines; Burlington Industries in North Carolina; Prudential in Oklahoma City; R. J. Reynolds in Winston-Salem; General Mills, 3M, and Honeywell in Minneapolis.

The above examples are only a few of those that might be mentioned in each category. Also, there is considerable overlap between the activities: coalitions often have utilization review, HMO development, and wellness program sponsorship as priority tasks. Finally, patterns of leadership do begin to emerge, and will be reinforced by the examples that are used in the next section.

IN-HOUSE POLICY AND PROGRAM DEVELOPMENTS

In-house efforts revolve around the re-design of the benefit package, and where most effective, begin with the development of a cost utilization data base that gives the firm the opportunity to select targets of opportunity based on evidence of real need that cannot be refuted by the employees, unions, hospitals, or physicians. Deere has a model data system and its importance is reflected by the fact that they could be an example of corporate leadership in almost every category throughout this paper.

On the cutting edge of benefit re-design are those firms that are experimenting with "cafeteria" plans that include multiple health plans with varying employee costs. The most advanced examples are TRW, American Can, Sun, Polaroid, and Pepsi. These efforts are essential building blocks for the proposed "competition/consumer choice" plans that Congress and the Administration will be developing throughout the next few years and which, in their early editions, contain mandates for major changes in the design, financing, and management of employee health benefits.

Currently, there are a myriad of cost management efforts that major employers are conducting. Examples include:

Reimbursement reform is focused on changing economic incentives so care can be provided in the appropriate settings and by the most cost effective providers: (A) General Electric: Hospice Care; (B) Deere: pre-admission testing; (C) Bank of America: pre-determination for dental; (D) IBM: tuition reimbursement for wellness programs; (E) California Psychological Health Plan: causing reductions in hospital, surgical, and medical utilization for many California employers; and (F) Reynolds Metals: (and many others) experiencing significant savings in both economic and human terms from Employee Assistance Programs.

Corporate policy reform includes the designation of a new position that many are calling the "health manager". This position assumes responsibility for the integration of all company health activities including benefits, medical, community action, and cost management. Examples include Caterpillar, Deere, FMC, and Sun.

Other companies have established wellness policies that either prohibit (Johns Manville) or restrict smoking; change cafeteria menus and the contents of vending machines; alter work hours to lessen stress; or provide time and/or facilities for fitness (Exxon and Xerox).

Another aspect of cost management has been the institution of new policies for corporate contributions (Citicorp and Continental Bank are two examples).

Incentives and behavior change programs are increasingly significant elements of the total cost management effort. Mobil Oil provided rebates for those divisions that recorded less medical utilization than was projected. Hospital Corporation of America gives cash prizes for levels of exercise accomplishment. American Can rewards those who select low option health plans with the opportunity to increase other benefits such as pensions or vacations. Pratt & Whitney provides employee counseling to assist in the selection of hospitals and doctors. Georgia Pacific and Mobil Oil have psychiatric assistance for employees and families moved to new locations. Gates Rubber has a loan program to reduce stress resulting from accumulated financial problems.

Within the context of behavior change, several groups (Midwest Business Group) and companies (IBM, Deere, Chrysler) are providing cost management education programs for their employees who serve as hospital trustees.

AN APPROACH TO HEALTH CARE COST MANAGEMENT

(By Willis B. Goldbeck)

INTRODUCTION

If the message had begun to slowly sink in, the 1981 budget cuts proposed by President Reagan and enacted by Congress, delivered the word with all the force of an emergency telegram: this nation cannot, and will not, afford all the medical care that its residents and the providers demand.

Cost management, or as it is more popularly known, cost containment, is not a new concept. Ever since the employee benefits explosion during World War II, employers have been tinkering with benefit designs that attempted to control costs without limiting the actual benefit. However, two major differences separate the period of the 1940's–1970 from the current period which one might roughly identify as having started in 1974.

First, the earlier period was founded on the ideology of giving benefits to increase access to services, thus representing a conscious effort to increase people's ability to utilize services while separating them from having that utilization restrained by the cost of the service. Today, the emphasis is exactly the opposite. We are, in effect, recognizing the economic consequences of being too successful in meeting the objectives inherent in that access-oriented ideology. Demand and supply have risen virtually unchecked by the normal rules of economics and in little relation to real need or any rational allocation of resources to either meet real needs or provide services in the most cost effective ways available. The climate today is dominated by the pressures of costs that seem to rise inexorably in a period of declining resources and a vox populi that, at least according to many political interpreters, calls louder for cost restraint than for increased access to care.

Second is the dramatic increase of governmental involvement, especially at the Federal level, as measured both by the impact of the mid-1960's creation of medicare and medicaid and by the growth of regulatory programs in the mid-1970's that were a multifaceted attempt to control costs. Throughout this period, the role of Government as the largest single payer of medical care costs legitimized the regulatory efforts, as reflected in the creation of such programs as health planning and PSRO, and investment in developing alternative delivery systems such as health maintenance organizations. At the State level, the advent of rate setting programs was an example of Government attempting to do what the Nation's antitrust laws would never allow the private sector to do itself. During this period, the Government's attempts at cost regulation were more than counteracted by increases (some would say excesses) on both the demand and supply sides and the continuing effort to guarantee access to care and improve the quality of care. Without regard for the relative merits or values of any of these efforts, the fact remains that today, and in the foreseeable future, the emphasis has switched from attempting to regulate costs while improving access, to one of reducing expenditures while accepting the harsh reality that such reductions will mean reduced access.

In sum, Government is saying that it will stop paying for both insurance and programs that had, until 1981, been deemed to be within the purview of Federal responsibility. The States and the private sector are expected to assume responsibility or accept reductions in protection and service programs. Simultaneously, the Government is attempting to design and subsequently put into law, changes in the economic incentives that govern the way consumers (individuals and their collective agents like employers) buy care, and the way providers (hospitals, other institutional settings and all categories of physician and non-physician professionals) sell their services. "Market forces" rather than public or private entitlement is projected as the way to ultimately control costs. Cost management will continue to be necessary, and some would say increasingly essential, regardless of the political future of the so-called "competition" system.

Private sector employers, especially the very large companies, have been faced with the same progression of cost increases as the Government. In fact, since all Government health insurance and programs are financed through tax dollars derived largely from payroll and corporate taxes, it would be safe to say that the major employers have been the primary recipients of the cost increases. The big companies have one distinct advantage over the Government when it comes to taking acting that is designed to produce improved short-term cost management. Since so many of the major employers have already granted medical benefits at or near 100 percent coverage, they have been able to address their cost management objectives without the conflicting need to expand access that traditionally plagues governmental efforts. Small business faces exactly the opposite situation with demands to provide basic insurance far exceeding demands for cost containment.

It is the purpose of this paper to present an overview of the major cost management efforts of the private sector employers with a focus on the 1974-1981 period. There are courses of action taken by private sector employers in their efforts to become prudent buyers of medical care services and insurance that could be transferable to the public sector and may, in the long run, prove to be of greater value for society than the legislative/regulatory approach.

It should be stated at the outset that this paper is not an attack on regulation. During the past few years, many private sector employers have found significant value in selected regulatory programs. In addition, these same programs have made many hospitals dramatically improve their own planning and management, which itself should have a positive impact on the quality of care given in their communities. Those in the private sector must acknowledge that the Government has multiple responsibilities, many of which, such as cost restraint and access enhancement, are inherently in conflict. Those same private sector employers must also acknowledge that it has been the basic design of insurance benefits that they created which has produced the perverse economic incentives dominating the reimbursement system today. Since the public sector insurance programs followed the private sector model, Government cannot be blamed for this aspect of the overall problem. It is also true that the private sector payers have, at least until very recently, not acted as prudent buyers.

However, the fact remain that most of the cost restraint with which regulation may be credited can also be viewed as cost shifting to the private sector payers who have been lax in demanding a comparable degree of accountability and lack the authority that eminates from the Government in the case of regulatory efforts. The recent Supreme Court case that found against an insurance company's cost control efforts on the basis that they lacked any governmental authority is the most recent proof of this problem.

A final introductory word: It is the bias of this author, and the premise of private sector cost management itself, that the payers have the responsibility to design incentives that will force the providers of services, within the limitations of their professional responsibility to their patients, to please the payers rather than the regulators or any intermediaries. Not only is this consistent with the basic tenants of buyer/seller relationships, it is also the only way that the medical system will ultimately reach an acceptable compromise between demand and need, between access and cost management, between quantity and quality.

FORCES FOR AND AGAINST CHANGE

As payers, the private sector employers and the Government have identical cost management objectives and face many of the same forces for and against change. The perspective of this paper is the decade of the 1980's. Unfortunately, the primary driving forces that govern both the demand and supply sides of health economics lead one to the conclusion that a goal of significant cost management will be extremely difficult to achieve. Or, to put it differently, cost increases will only be modified if certain conditions prevail and certain values are accepted.

A. Changes, whether voluntary or regulatory, must involve all payers, public and private.

B. There is a massive educational effort aimed at making the public more aware of their own responsibility for their health, and for acting as prudent buyers/utilizers of medical care and its insurance; aimed at making the large private and public institutional buyers responsible for benefit design and accountability systems that give them the capacity to manage their health care resource expenditures with the same degree of scrutiny that they would apply to any other purchase for which both quality and quantity were important; and, finally, aimed at all types of providers so that they will be aware of the economic consequences and alternatives available within the range of each decision they must make, each order they approve or initiate.

C. We demonstrate a national commitment to health that is at least on a par with out historical, and very successful, commitment to the best medical care. Prevention, or wellness, is neither a fad nor the enemy of medicine: it is the embodyment of old and new knowledge combined with the medical and economic imperatives that so clearly show significant health status being independent upon lifestyle and the preservation of sufficient revenues to meet the true need for acute care beind dependent upon preventing otherwise unnecessary demand.

D. We publicly accept that our care delivery system will always involve some rationing, rationing that, while economic in nature is inherently a question of ethics and values.

E. Cost management must involve strategies that encompass the troika of health care economics: utilization, capacity, and reimbursement.

One of the reasons that the cost management climate is currently discouraging is that several of the major economic forces pushing costs up and resources allocated to health down are outside the control of the health care sector itself. These need to be understood in order to appreciate the limits to cost management opportunities, to make priority decisions among those opportunities, and to develop the system-wide changes that so many health policy experts feel are essential for lasting progress.

1. COSTS AND DEMAND WILL INCREASE THROUGHOUT THE 1980'S

(a) The aging of the population will place an unavoidable pressure on demand: Those over 65 use twice the care services as those under 65; those over 80 use twice that of those between 65–80; and the fastest growing population group is those over 84.

(b) Medical technology is both labor and capital intensive, and increases demand for services by increasing our capacity to respond to what was previously "untreatable." Examples include new drugs, spin-offs from the space program, regeneration, genetic engineering, inplantation and perhaps most important of all, telecommunications developments that will dramatically change the delivery system, education and patient-provider communications.

(c) Population growth, contrary to public opinion, is headed up rather than toward zero population growth." Although not yet at a rate of growth sufficient to cause national concern, there are several States which are at their all-time high and the trends suggest an increasing clash between young and old over limited resources. And, although seemingly too distant to be of concern, the crushing problems arising world population growth, especially in the developing nations, will further exacerbate our domestic resource allocation problems.

(d) One of the unique features of health economics is the reverse correlation between quantity of providers and price/volume increases. Normally, the more providers, the more competition and thus the more price and volume on a per-provider basis are reduced. In the case of physicians, the opposite has been true. The supply of physicians is growing much faster than even the most conservative estimates of need. One evidence of the degree to which physicians recognize the potential impact of this growth in supply was the recent decision by the AMA to oppose further Government financial assistance for non-physician medical education. As the numbers competing for their share of an increasingly stringently managed economic pie grow, we can expect some new acceptance of old ideas like prevention and prepayment. However, we can also expect efforts by threatened physicians and hospitals to close the market to new competitors.

(e) Environmental factors that increase health hazards, both known and suspected, are sure to be a major demand inducing influence during the coming years. Not the least of this problem is the uncertainty and fear the public associates with such problems as nuclear and toxic waste, acid rain, and the increasing number of communities that have little or no water that is safe for human consumption.

2. REDUCED RESOURCES ALLOCATED TO HEALTH CARE SERVICES

(a) Medicaid is being reduced by the States. This is to be compounded by the "reforms" proposed by the Reagan administration. Rationing plans based on income, length-of-stay and other criteria are resulting in decreased services and increased cost shifting to private sector payers.

(b) Medicare recipients are being required to pay increasingly large shares of their medical costs "out-of-pocket" and there is already talk of a Federal cap not unlike that now being considered for medicaid. Perhaps even more important is the recent announcement that the medicare trust fund will be depleated within the next few years. One can expect that the horizon on this economic crisis will get progressively closer.

(c) In 1981, the Federal health care budget was reduced explicitly to make more funds available for the defense budget and as part of an overall effort to reduce Federal spending. Therefore, the die seems cast for an era when health will increasingly have to fight for its share of the Federal pie, a concept that was called virtually unthinkable only 3 years ago, and is beyond the control of either the health industry or its patients.

(d) Private sector payers are increasingly revolting at the cost shifting and seemingly endless cost increases that appear unrelated to improved health, improved benefits or even increased numbers of persons covered. Their actions, if successful, will result in a reduced rate of cost escalation and even greater pressure on local government and hospitals; the institution of last resort.

(e) Finally, all voluntary efforts, can only be successful if some receive less than would have otherwise been the case. This simple fact guarantees and legitimizes a degree of adversarial relationships at the local level between those who have had control and those who are starting to exercise economic pressure to gain control.

The picture painted above, while not encouraging, gives a reflection of the severity of the problem that should be more than enough to make any public sector payer or regulator welcome the opportunity to emulate any effort of the private sector that holds promise of even marginal success at cost management. As a practical matter, neither the public nor private sector payers have any economic choice other than the pursuit of effective cost management. Their success will depend to a considerable degree upon their ability to share and cooperate.

EMPLOYER COST MANAGEMENT OPTIONS

Cost management efforts can be thought of as addressing three basic questions: First, what will we pay for? Second, what do we need to know to make prudent buyer decisions? Third, what do we need to change so our decisions will have an impact?

Employer experience at cost management covers a wide range of options which are organized below into categories, necessarily arbitrary, to give the reader a good feel for the options without suggesting that every possibility, much less every meaningful example, is included.

OPTION I: CHANGING ECONOMIC INCENTIVES

It is now generally recognized that the design of the health insurance benefit will greatly influence its utilization by the insured as well as the services and their price as charged by providers. The focus of benefit redesign today is to change these incentives so that patients bring their utilization closer into line with real need, and the providers give the types of services, in the settings and with the levels of professionals that will result in the best available mix of quality and cost efficiency.

There are numerous administrative steps, such as coordination of benefits so that members of the same family do not receive duplicate coverages just because they work for separate employers. These will not be discussed in this brief paper.

Economic incentive change efforts can be considered in four categories (financial, locational, services and providers, and consumers) all of which can be developed independently but none of which will be as significant alone as they would be collectively.

A. FINANCIAL

(1) Cost sharing is the most obvious tool that attempts to make the user/patient more price sensitive with the hypothesis that a reduction in utilization will result. While seemingly logical and already present to varying degrees in a majority of employee benefit plans, cost sharing is less than a proven technique. To be a truely effective utilization deterrent, cost sharing raises the spector of treatment avoidance which, many fear, only causes delays rather than savings; delays that themselves may be cost inducing since the utilization that is avoided due to cost sharing tends to be more preventive, and thus most cost efficient in the long run. Another problem with cost sharing is the difficulty of stopping people from buying other insurance to protect themselves from costs that may be incured through high deductibles or other shares for which they are responsible. Designing a cost sharing schedule that is income sensitive is another problem. Finally, the history of making cost sharing disease specific, such as providing far less coverage for mental illness than for physical illness, has proven to be a costly error rather than a cost saving. Cost sharing is clearly the trend in both private and public insurance, but the reader is cautioned not to expect major savings, unless one is content with very short-term measures. The recent Rand Study preliminary results confirm that cost sharing does

modify utilization and does caution that, for the low income, the impact may hinder needed care.

(2) In- us out-patient care; here, the rules of economics do apply. As long as insurance pays for care given on an in-patient basis but not if rendered on an out-patient basis, we cannot be surprised that both patient and physician select the in-patient setting. The trend these past 7 years has been to lessen or remove the bias against reimbursement for out-patient care. The result is predictable. There has been a great growth of claims for out-patient care, hospitals are building out-patient facilities, and total medical care costs have not been reduced. Again, we should not be surprised. The addition of any new capacity, in this case out-patient, will result in added costs unless there is a concommittent reduction in the in-patient capacity. In fact, those who seek cost management must recognize that changing the benefit design may shift costs to more appropriate settings but will not contain costs unless the total capacity of the delivery system is also changed with a resulting change in total utilization. If more care is delivered on an out-patient basis, the cost of in-patient care must go up on a unit basis unless the capacity is reduced. In addition, the development of the new out-patient capacity becomes a demand generator itself. None of this is necessarily bad, but it must be understood or else the sponsors of cost containment programs will have their expectations dashed when they discover the result in a rearranging of costs rather than a reduction of costs. This is further evidence that cost management programs need to be conducted in an integrated strategy.

(3) Prepayment rather than retrospective reimbursement is another cost management tool that has gained considerable favor among private employers in the past few years. The concept is simply one of putting the provider of the service at some financial risk thus reversing the economic incentives inherent in the traditional insurance system which rewards the provider who generates the most charges. In the prepayment system, the inventive is to minimize utilization and minimize capacity expansion in-order to maximize the amount of reimbursement agreed upon in advance. Health Maintenance Organizations are but one manifestation of this concept, a concept that has grown in favor far faster than the institutional response that is necessary to make it have a nationwide impact on health care costs. The value of the prepayment system can be seen by studies which show dramatic reduction in hospitalization for HMO enrollees, without any evidence of reduced quality of needed care. Concerns for the potential of under-utilization warrant attention but the need to avoid more expensive care in the future is viewed as the primary check against any conscious effort to deny needed early access. In the public sector, these same advantages await the elderly and poor . . . as soon as Congress will make prepayment systems an attractive option in medicare.

(4) User incentives is another mid-1970's development. Some companies, such as Mobil Oil, have programs which reward employees who minimize utilization. A Blue Cross "stay well" experiment in California offers cash rebates if the funds designated for medical care go unused. Other companies are paying cash incentives for lifestyle risk reduction programs such as physical fitness; life insurance companies are reducing premiums for those who are not smokers. Credits obtained by the selection of lower cost insurance options may, in some leading firms like TRW and American Can, be used to increase retirement or other benefits. Rebates as the incentive to select a "low-option" insurance plan are a basic component of the "competition" national health policy legislation now being supported by the Reagan administration and many in Congress as the long-term cost management system.

B. LOCATION

A product of cost concerns and increasingly available information about alternatives, the consumer/public has been expressing a shift in values that makes acceptable the delivery of care in locations other than acute care hospitals. No longer is quality automatically equated with sophisticated technology, or even an institutional setting. Not only is this shift a rather visceral rejection of the dehumanizing aspects of some technology, it is also supported by research that shows, for example, certain categories of heart attack victims who are treated at home have recovery rates at least as good as matched groups treated in intensive care units.

(1) Hospice; the value shift mentioned above is epitomized by the growth of interest in hospice. Hospice is a concept of care for the terminally ill that places dignity for the dying and concerning for the bereavement of family as priorities of greater import than medical care. The concept may find its application in the home, special hospital units, or distinct hospice facilities. Local and state health plans have increasingly considered hospice necessary for a comprehensive community delivery

system. In the private sector, it was the decision of General Electric to include reimbursement for hospice care in their health insurance plan that is considered the proof that this system of care represents the convergence of the need for cost management and the emerging ethic that gives highest priority to the quality of life as defined by the patient rather than the intensity of care as defined by the provider.

(2) Ambulatory surgery; private employers are increasingly providing reimbursement for surgery performed in ambulatory settings. Each year, research and experience adds to the list of procedures that are now considered safe for treatment in an ambulatory facility. In considering the cost effectiveness of ambulatory surgery, it is factors outside the treatment itself that are most significant: no overnight stay in hospital, reduced chance for nosocomial infection, less overhead per procedure, and, obviously, significantly reduced manpower demands during the recovery period. Questions remain about the extent to which the ambulatory surgery concept can be extended to more procedures, and about the relative safety of procedures done in an embulatory unit of the hospital or in a free-standing facility, but there is little question that employers, through their reimbursement policies, will be acting as prudent buyers only if their benefit package includes ambulatory surgery where quality facilities exist.

(3) Home care; the home care concept is not new. Few would argue that many patients now hospitalized or placed in nursing homes could be treated at home for far less money, with no reduction in quality of care, and with reduction of the emotional stress caused by institutionalization. Private employers frequently include reimbursement for home care in their benefit plan, but usually do so at a level below that of hospital care, a practice that reinforces the wrong economic incentives. In recent years, employers have been correcting this bias, up to the point where the services become "custodial." For many of those whose medical care can be safely provided at home, the largest obstacle is the absence of resources to provide for assistance with cleaning, cooking, laundry, shopping and other functions which are indeed custodial in nature. Proposed legislation such as S. 234 (Senator Hatch) seeks to require reimbursement for such services based on the hypothesis, proven in the eyes of many, that cost containment will only be achieved when home care becomes a reality for all who have no medical reason to be treated in more expensive settings. If custodial services are the barrier, then it is custodial services that need to be provided. The rate of savings, considering the price of an acute care hospital room, or even a nursing home room, compared to a day of home care with custodial services, makes concerns for potential abuse appear too insignificant to accept further delays, especially in light of the aging of the population.

(4) Hotel vs hospital; one of the most controversial innovations in reimbursement is the increasing practice of paying for hotel/motel lodging instead of a night in the hospital. Clearly restricted to those instances when hospital admission is for convenience rather than for medical necessity, the concept can be a significant cost saver when one considers that, in most cities, the most expensive hotel costs far less than the hotel function of the hospital.

C. SERVICES AND PROVIDERS

(1) Wellness, or health promotion and disease prevention is being adopted by many private sector employers as what one might call the "new benefit." The logic is compelling: by far the best way to reduce demand is to prevent illness. We know that today's major illnesses are directly related to our lifestyles and thus are amenable to risk reduction through well designed programs of education and prevention. In addition, evidence of cost effectiveness accumulated by employers is causing many others to build these new services into their health plan. For the public sector, it is important to use measures of effectiveness that are realistic (absenteeism, productivity, morale, turnover, accidents, and hospital/surgical/medical utilization), but not to rely on improved morbidity and mortality, the payoff from which is not only controversial, but also too far in the future to influence today's corporate decision making.

Wellness programs range from single issue programs like smoking cessation, alcoholism, fitness, stress reduction, nutrition, etc. to comprehensive programs, such as the Health Care Management Program at New York Telephone, Live for Life at Johnson and Johnson, Stay Well at Control Data, the extensive community referral program, Live For Life, initiated by IBM, Xerox' Health Management Program, Citicorp's Manage Your Health, and the pioneering work done by Kimberly Clark.

One example of an insured wellness benefit that has been cost effective is the California Psychologial Health Plan. CPHP is a simple system that recognizes that most person's emotional problems, and many of our physical health problems, have difficulties with coping skills as their derivation. CPHP provides immediate access, with no deductibles, to a small number of counseling visits. If either more visits or a higher level of practitioner is needed, a peer panel of professionals must review the case before reimbursement will be allowed and a schedule of deductables begins. Results have been so impressive (greater than a 20 percent reduction in hospital/surgical/medical utilization) that insurance carriers are offering the benefit at no or very low cost and some are making the acceptance of this benefit a requirement for all their health plans.

(2) Nonphysician providers, such as social workers, physical therapists, and wellness program trainers can provide services integral to a well designed benefit package, but will do so only if the reimbursement system provides for their pay, and does so in a way that does not compound costs by having the billing go through physicians. Industry has long depended on nurses to conduct the majority of industrial medicine clinics, so the use of other nonphysician providers is not an alien concept. However, as economic pressures mount on physicians, it is predictable that efforts will be made to restrict the use of nonphysician providers. As has been the case with nurse midwives, the restrictions will be presented under a banner of assuring quality of care but the honest cause will be economic protectionism.

(3) Self care is another area of growing interest due to its cost containing potential. Not amenable to insurance, self care is consistent with the need to make the individual increasingly responsible not only for the financing of care but also for the conduct of as much prevention, care and prudent utilization of the delivery system as possible.

D. CONSUMERS

(1) Multiple choice, whether between indemnity and prepayment plans, or among indemnity plans with a variety of coverage levels, or between health benefits and other employee benefits through "cafeteria benefits", is a concept based upon the theory that consumers will become more prudent buyers of their insurance if they are given economic incentives that are not part of the normal employee health benefit system. It is not known how effective this concept may be. Few employers have extensive experience but those that do have found extensive movement away from the costly high option insurance plans. There is also considerable concern that those who select the low option are already the most healthy, thus causing an increase in the cost of the high option for those who have no choice due to their medical condition. This would defeat the risk sharing principle of insurance and result in cost shifting rather than cost saving.

OPTION II: INFORMATION, THE KEY TO COST MANAGEMENT

Option I discussed a variety of ways to use the inventives in reimbursement to change the ways consumers and providers use the delivery system. These methods have failed to be as successful as many assumed, back in the early 1970's, due to the absence of the data and information that is now known to be essential for either the individual or aggregate consumer to become an effective prudent buyer. The development of new data and information systems has been aimed at two objectives: accountability and education.

A. ACCOUNTABILITY

Historically, private sector payers have demanded little information that would enable them to track their medical dollars and relate expenditures to any measures of quality. Even fraud and abuse, decryed in Government programs, went undetected in the typical private employer plan. Today, this is changing.

(1) Self-insurance, or more correctly, self-funding, has awakened many employers to the need for data systems to manage the allocation of those funds and the claims they were to pay.

(2) Utilization review, especially by contract with PSRO's and Foundations for Medical Care, have frequently been credited with reductions in average length-of-stay of a full day or more, with no reduction in needed care. Caterpillar, Goodyear, Deere, and Motorola are examples.

(3) Price and service comparisions have not been welcomed by the medical profession. However, research by health care experts like Dr. Richard Egdahl at Boston University, is showing the value of payers being able to identify "outlyer" providers, those whose quality and/or pricing fail to meet or far exceed accepted standards. Employers have been reluctant to point the finger at specific physicians or to direct employees to or away from certain providers or facilities. However, the results of an

employee information system conducted by the medical department at Pratt & Whitney in Florida is making other companies reconsider. Their system has had a direct and fast impact on local physician charges resulting in savings not only for employers and employee, but also for the community. The critical point is that these savings cause increased quality of care as well as producing revenues that can be reapplied to real health needs.

(4) Claims administration systems have been around for a long time but only in the past few years have companies like US Administrators developed the capacity and political will be demand the highest level of provider accountability with major savings resulting for firms like Bank of America.

(5) Preadmission testing is increasingly a requirement of private employers. Most utilization review systems do not cover the short (1-3) day hospital stay despite the fact that these are often very expensive days. Firms like Deere have found the preadmission program to be an essential cost management component. US Administrators has used a predetermination system for dental cases and is now applying that same degree of accountability to nonemergency surgery.

(6) Second opinion programs are designed to give (or to force) the patient to receive a consultation before reimbursement will be allowed for elective surgery. Early studies suggested that a significant savings would result from surgery avoided due to rejection by the second (and in some cases third) opinion. Those who are less optimistic suggest that costs are more delayed than avoided. Faced with inconclusive results, many companies are continuing their programs and justify the expense on the basis that the education the patient receives has a value even if the surgery is ultimately performed. The longitudinal data accumulated by the Storeworkers union in New York City shows that even after 8 years, those who were first recommended for surgery and then received a contrary second opinion, 20 percent still have no need for the surgery.

(7) Finally, new utilization standards are being developed and tested (the DRG system in New Jersey being the most well known, large scale effort) for the express purpose of giving the payer the capacity to relate expenditures to physician practice patterns and to health outcomes. Once again, if done well, the result will be a convergence of cost management and quality of care improvements. The impact can be gauged by looking at the HCFA DRG data for length of stay (LOS) for 142 Colorado hospitals. Using that one simple measure, those hospitals had 77,500 days above the average for the western states in 1980. Those wasted days not only waste millions of needed dollars, they also waste an undetermined number of lives.

B. EDUCATION

The accountability systems described above are also an educational tool for the payer, and for the provider who has historically not been faced with this level of scrutiny and thus has had little incentive to become aware of the economics of care being provided. Several other educational efforts are necessary in order to maximize the total cost management/prudent buyer program.

(1) Trustees of major hospitals are often corporate officers and local public officials. Rarely do they bring to the hospital the same business acumen that made them successful in the first place. In the past four years, several employers have sponsored educational programs to help teach their employees who are also trustees about health economics and the companies' cost management objectives. GM, Chrysler, Deere, and IBM are among the companies that have had successful programs; the University of Minnesota, Boston University's Center for Industry and Health and Care and the Washington Business Group on Health are all active resources for such training programs.

(2) Providers, studies consistently show, know precious little about the cost of the procedures they order. Even more important, when educated, they tend to adopt more cost conscious patterns of practice with little difficulty. Studies in the past three years have shown that residents can have their use of lab tests reduced by more than 40 percent if they participate in a chart review program. Equally dramatic results are obtained when other education programs are given in relation to the value of lab tests for diagnostic purposes. Physician orders are reduced when the unit price of the order item or service is known . . . all without reduction in needed care.

(3) Employees and dependents cannot be expected to change generations of behavior, an inculcated acquiesence to physicians, and the negative influence of the economic incentives remaining in many benefits plans unless an investment is made in the education that will let them be the prudent buyers we all desire. To do this, employers and public sector agencies alike must make clear the relationship be-

tween cost management, improved quality of care and resources saved for application to needed care, not saved to increased corporate profits or to add to the defense budget. Like any other social and behaviorial change, an effort must be made to build a constituency.

OPTION III: CHANGING SYSTEMS, PARTNERS AND VALUES

Cost management of the magnitude that is required to satisfy the economic imperatives facing our country today cannot be accomplished unless there are changes in the systems of care financing and delivery; in the partnerships among payers, providers and consumers; and in the values that we all express through our private behavior and political will.

A. SYSTEMS

Among the private companies that have done the most large scale and innovative cost management programs has emerged a consensus that, to be really successful, a company, and this would be equally true of a public sector agency or state, needs to have a health care strategy. Firms like IBM, Deere, Caterpiller and Goodyear have been reasonably successful because they made the investment in executive leadership and the commitment of resources necessary to give innovation and systems change a chance. Cost management, like any other management system, cannot be done cheaply, unless you are satisfied with a cheap result. The success any specific company experiences, and the size of their commitment, will be effected by the total economic condition of the company, just as would be the case of any local government. However, the more farsighted companies see the investment in cost management as an integral component of responsible management of the firm's total assets.

B. PARTNERS

Cost management cannot be achieved by employers alone. While granting that there will be times and places where previously friendly relationships do become adversarial, the fact remains that progress will ultimately depend on the forging of new understanding and new partnerships for the common goal of a quality system that the country can afford. Local purchaser or health care coalitions will all need to find ways to bring the provider and payer together.

C. VALUES

No issue better exemplifies the need to change systems, built new partnerships and re-examine our values than does school health education. Employers are increasingly aware that they cannot expect the next generation of employees to act as prudent users of their health benefits if they have had no education about health throughout their school years. Employers also sit on school boards and have the opportunity to deny the excuse that a community cannot afford health education because they know from the cost of their own medical programs that, in fact, the community cannot afford not to have health education. Further, employers are beginning to realize the billions paid in medical care costs and AFDC taxes resulting from the nearly 1½ million teenagers who become pregnant every year. These are problems that cannot be solved by employers, and will not be solved without employers.

EMPLOYER-GOVERNMENT COOPERATION

Since 1975, private sector employers have been increasingly aware that cost management can only be achieved when all categories of payers work together or at least adopt compatible courses of action.

1975 marked the start of very large insurance premium increases as the health care industry began to catch-up after being the last industry to be released from the wage-price controls of the economic stabilization program. Employers who paid charges were hit with the additional impact of cost shifting as hospital's bad debt ratios grew with the declining value of medicare and medicaid reimbursement. With Government paying some 40 percent of the health care "bill" and in many communities being the largest employer as well as the payer and regulator, leading private sector employers increasingly saw the necessity of developing cooperative relationships.

Government itself provided three avenues for joint efforts: planning, PSRO, and State rate setting. The employer community has been split in its reaction to the State rate setting programs. Little has been done by the States to involve the private sector. Many employers are opposed because they oppose any new governmental interventions. On the other hand, many did see the need for structural cost containment and felt they would benefit if the programs would really work. State programs seemed like an equitable and potentially valuable way to address the tough issues that no private payer could control on their own. If successful, some saw the State programs as a hedge against further Federal attempts at national health insurance.

Early evidence indicated that the programs were not very effective. The voluntary program in Indiana had better results than most of the mandatory programs. Today, however, evidence is growing that the regulated states, especially Maryland, are experiencing significantly lower rates of cost escallation than are the nonregulated states. If this continues, the employers' desire for cost control may well exceed their traditional antipathy for regulation.

The lesson from health planning is that the payers can and must participate in the resource allocation decisions. Thus, if planning is to be left to the States, with no Federal requirements of consumer participation which was the vehicle through which employers gained the opportunity to become involved, then these same employers will have to find new ways of working with the States to assure that their voice is heard. The employers who have been involved with planning are those who are most supportive of a continued commitment by the Federal Government.

PSRO, or utilization review participation by private employers gives the same message as planning. With the potential demise of the Federal programs, private employers are left little choice but to develop their own review programs. This will be slow and gentle in some areas, but many providers will find that facing a wide variety of private payers all demanding their own review systems will be more complex and considerably more severe than were the old PSRO's.

A new and untested avenue of cooperation is the growing institution of state wellness councils or commissions. Usually with the personal involvement of the Governor these bodies offer another way for private employers to become increasingly visable participants at the state level. Encouragingly, some of the more developed programs, like that in California, are seeking private sector involvement.

Michigan provides the best example of the final cooperative venture to be discussed: cost management legislation. Although most employers are not prone to seek legislative solution, Michigan shows what can happen when costs continue to mount and the leading industry is facing serious economic problems. No longer able to simply pass on health care cost increases to the buyers of their cars, the auto industry, working with the UAW, actively assisted on the design and passage of a law for the express purpose of reducing the number of beds deemed excess by the current Federal standard of 4.0 beds per 1000 people. The same employers and union also worked together with the State on the creation of a large HMO in Detroit, again demonstrating that concern for costs can create partnerships that would otherwise be almost impossible.

OPPORTUNITIES AND CHALLENGES

Private sector cost management experience does provide valuable lessons for the public sector not the least of which is to avoid the illusion of a "quick fix". In the next few years, we will experience several themes in health policy that will provide exciting opportunities and challenges for all parties in the health care system.

a. Competition

Regardless of what happens with Federal legislation, the concept of trying to induce more market forces into the health care system will be dominant during the rest of the 1980's. Private employers, through existing experiments and the growth of cafeteria plans offer a proving ground for the competition theories. Several leading firms are going ahead on their own to offer more consumer choice among plans, but no single employer has the market domination to provide a satisfactory national test by itself.

b. Coalitions

For the very reason just mentioned, employers are increasingly banding together in local business groups on health, or coalitions, to create the collective market strength than none have separately. To date, most coalitions are primarily educating their members about the health care system and its economics. A few, such as Penjerdel in Philadelphia, have developed a utilization data system and are applying their economic clout to assist the certificate of need process, as well as helping to establish competing providers in ambulatory surgery, HMO and hospice programs. As the planning and PSRO programs are eliminated, many have suggested that the local coalitions become the regulator. To do this successfully, without the support of State or Federal legislation, will almost inevitably bring charges of antitrust violations. The need for purchasers and providers to work together is clear, but it is equally clear that real cost management means that someone will be getting a smaller share of the pie tomorrow than they are today.

c. States, partner or problem?

Not only are many of the Federal regulatory programs being eliminated, and the Federal share of entitlement programs being reduced, but the States are also being given new block grant programs to replace most of the Federal categorical health programs. It will be many years before we learn whether or not this was a cost effective move from an administrative perspective. However, we will know much sooner how serious the States are about cost containment. If the history of health planning is a valid lesson, the future is grim. States have been far more willing to succumb to political pressure to use an expanding health care industry for economic development than they have been to accept the local communtities desire to restrict that industry for cost containment objectives. Private employers will have to make a strong effort to develop a presence for influencing State health policy decision.

d. Access will not be a dead issue

Despite the shift in emphasis from access to cost management, it is predicted that the access issue will not go away. The elderly are one of, if not the loudest political voice in America; costs will continue to rise and the issue of "catastrophic" coverage will never by farther from Congress than the next mail delivery; insurance pools have proven to be an effective way to close the gap for those deemed "uninsurable" despite their ability to pay. Other States are sure to follow the Connecticut example, thus adding to the ranks of those covered by insurance. Small business will be increasingly pressured to provide at least some basic and major medical insurance. New group arrangements that pool the employees of more than one company are being created. Every indicator suggest that people are still more concerned about the possibility of future medical care costs that they will not be able to pay than they are about today's premiums.

e. The hospital of the future

All these changes, stimulated by the dual objectives of access and cost management, mean that the hospital will also change. Certainly, the change is already underway as can be seen through the rapid growth of the propriatary chains and multihospital systems. Equally important is the growth of corporate restructuring by the voluntary hospitals. The future hospital will be a health care conglomerate with separate corporations using the various for-profit, not-for-profit, and pre-payment financing systems as they market a wide variety of services. Functionally, acute care will be the only business of the hospital as we think of it today. The other corporate components will be increasingly responsive to the ebbs and flows of economics and the onslaught of telecommunications.

CONCLUSION

For the long run, today's convulsions in the health care industry are undeniably healthy. During the next decade, we will be seeking a rebalance of the patient, provider, payer, regulator roles. From what we have learned in the past few years, two messages ring loudest: progress will only be made if we work together and share each other's experience. Two, we have the capacity and the economic incentive to build a health care system that is the equal of the medical system of which we have long been rightfully proud. The only question is, do we have the political will and personal commitment?

Chairman Jacobs. The next panel, National Association of Home Care, Chairman Mary Suther, and the American Federation of Home Health Agencies, represented by Mr. Morris B. Levy.

I am sure you both understand the ground rules under which you are operating.

Ms. Suther, do you have that right?

STATEMENT OF MARY C. SUTHER, CHAIRMAN, GOVERNMENTAL AFFAIRS COMMITTEE, NATIONAL ASSOCIATION OF HOME CARE (EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION OF METROPOLITAN ATLANTA)

Ms. SUTHER. Mr. Chairman and committee members, my name is Mary Suther, and I do represent the National Association for Home Care, a newly formed organization. This organization resulted as a merger from the National Association of Home Health Agencies and the Council of Home Health Agencies and Community Health Services of the National League of Nursing.

We represent hospital-based, official, combined, proprietary, private not-for-profit and voluntary not-for-profit home health agencies, agencies of all auspices. Also, I am the executive director of the Visiting Nurses Association of metropolitan Atlanta, and we serve an average caseload of 1,000 patients a day in the home, many of whom are medicare and medicaid patients.

On behalf of our organization and myself I want to commend this committee on its efforts to make decisions which will not adversely affect the elderly and disabled. Home health care is an underutilized part of the health care program and spectrum. Increased utilization of home health care can be an effective part of a comprehensive cost containment program for health services.

Since less than 2 percent of the medicare and medicaid dollar goes to home care, cost reduction in this area will result in relatively little impact on the budget. This association is aware, however, that the Federal budget must be reduced.

I would like to submit our written testimony into the record here. It does explore general home health, home health care, the cost effectiveness of that care, and the need for that kind of care.

Today I will be responding in summary to only the areas which would seriously affect the delivery of home care to the elderly and the disabled. The first area to which I would like to respond is the requirement for minimum coinsurance on home health services under medicare.

The validity of this projected $35 million in savings in 1983 is absurd. One, the only decrease in utilization would be in the lower income patient who may of necessity have to spend the coinsurance money for food or medical care for survival, thus putting the individual at risk for higher cost institutional care.

The coinsurance would have come to an average of only $2 per visit or approximately $12 to $15 a month. There would be a substantial effect on the agency billing operation, as all medicare patients would have to have two bills rather than one, thus increasing the cost of administration of the program more than the amount that would be collected from the program.

Coinsurance in many instances would be paid by medicaid, therefore increasing the medicaid costs. A substantial minority of patients who could conceivably eke the coinsurance payment out of their meager pensions would simply not pay the coinsurance, as was the case when coinsurance was required in prior years.

If agencies are reimbursed for their contributions, this further reduces projected savings. If they are not, this would put all honest providers out of business with the exception of those who have charitable or official agencies.

The preparer of the proposal utilized data from the GAO report, but failed to mention that the only agencies reviewed by the GAO for this report were agencies who had high home health paid utilization rates. Therefore, generalizations cannot be made from this study.

Second, elimination of the waiver or provider of liability for health care services. The basic assumption is incorrect. Medicare pays for a service that in the judgment of the intermediary is not necessary. The payment is made only if historically the intermediary agreed with the judgment of the provider, and over 97.5 percent of visits were home health care, not actually medical necessity, but what is adjudged to be medical necessity. If the service was denied by the intermediary as a result of the patient not being homebound, not having doctor's orders or any other technical reasons, the visits are not paid by waiver.

A 97.5 correction in judgment involving medicare is indeed an art and not a science due to the lack of consistency in interpreting the regulations by medicare intermediaries. The Health Care Financing Administration does not utilize any scientific methodology in evaluating the intermediary relative to their ability to make correct claims determinations.

Our association has requested that the intermediary look at reliability and validity in claims determination as part of the evaluation process. We were so concerned relative to the process that I developed an evaluation model and submitted it to HCFA, being cognizant that if the governmental agency knew how to do better, they would in fact do so. We did provide this model for them. The model is included in your written testimony.

The institution of such an intermediary evaluation model could indeed save far more than the projected $15 million projected savings in the proposal if indeed inappropriate claims are being paid. It is impossible even under the clearest regulations for a provider to be 100 percent correct in all its judgments all the time. None of us, you nor I, are 100 percent in our judgments all the time. Would it be fair for the citizens of the United States to prorate you or my compensation on judgments which they felt were not correct after the fact?

If this proposal were initiated, many agencies would go out of business due to the nature of the cost-based reimbursement system, thus leaving patients fewer alternatives to more expensive institutional care. The implementation of this practice could require agencies to bill medicaid for denied services. There would be a tendency in some agencies that do not have funds for indigent care to decrease utilization of home care out of fear that visits would be denied with a subsequent in utilization of institutional care by patients.

Line item costs could conceivably be reduced, but would result in subsequent bottom-line increases in medicare costs as a result of increased utilization of higher cost institutional care.

The third area I would like to address is the changes in supplemental security income eligibility and medicare an medicaid eligibility. The assumption of cost savings as a result of this proposal may on the surface be true, as medicare and medicaid rolls would be decreased temporarily. The fallacy of the assumption is in not looking at the longer term 6 months' effect of these cuts as these persons may delay health care until they deteriorate to the extent that their financial situation is affected, thus, entitlement to medicaid at a time when the cost of care is going to be greater as a result of the advancement of the disease and the deterioration process.

If this committee is really serious—and I believe it is—in wanting to trim dollars from the budget without adversely affecting the elderly and disabled, we propose: One, decrease unnecessary paperwork and duplication of effort by changing regulations which could result in a 20- to 30-percent or $150 million minimum cost savings in home care.

The national associations have repeatedly made recommendations for regulatory change which would not affect quality adversely but would increase efficiency and decrease cost. One such request is attached to my written testimony, 67 pages of it.

The cost savings of this proposal would not affect home care negatively as would other proposals, yet it would save more than the proposed $81 million in savings.

Second, we would request you consider the effects of any change on the home health care system, as changes in one area of health care can positively or negatively affect other components.

Chairman JACOBS. Excuse me, Ms. Suther. I have to tell you that your 5 minutes is almost up, because you have been talking for 7½ minutes. Can you finish pretty quickly now?

Ms. SUTHER. I thought I was the fastest talker in Atlanta.

In essence, I do know of personal instances where budget cuts have already adversely affected health care of people in our community.

Thank you for allowing us the opportunity to appear before you.

Chairman JACOBS. Thank you very much. I hate to say it, but 7 minutes and 45 seconds.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL ASSOCIATION FOR HOME CARE

Mr. Chairman and members of the Committee:

A. Introduction

I am Mary C. Suther, Chairman of the Governmental Affairs Committee of the National Association for Home Care (NAHC). This is a newly formed organization which resulted from a merger of the National Association of Home Health Agencies (NAHHA) and the Council of Home Health Agencies/Community Health Services of the National League for Nursing (CHHA/CHS-NLN). We represent hospital-based, official, combined, proprietary, private-not-for-profit, and voluntary non-profit agencies...agencies of all auspices. Also, I am Executive Director of the Visiting Nurse Association of Metropolitan Atlanta, Inc.; an agency which provides home health care to over 1200 people a month including many Medicare and Medicaid patients.

B. Opening Comments

On behalf of our organization and myself I want to commend this Committee in its efforts to make decisions which will not adversely effect the elderly and disabled. Home health care is an underutilized part of the health care spectrum. Increased utilization of home health care can be an effective part of a comprehensive cost containment program for health services. The demand for quality health care is a high priority for all citizens. The medical advances of the last several years have created highly technological methods of health care. Their higher technology, which in itself can be very costly, coupled with increased costs related to more highly skilled and mobile personnel in the health field have increased the cost of health care in general at a greater rate than the general inflation rate. Combine this trend with the natural tendency to associate quality with cost and current emphasis on institutionalization (high cost) health care over home (low cost) care becomes understandable. Since home health care is often more beneficial to the patient as well as less costly than institutional care the problem then becomes the promotion of health care based on appropriateness of treatment rather than public expectations. NAHC supports to the fullest extent possible utilization of home health care for both its positive contribution to patient care and for its cost effectiveness.

Home health services are professional health and supportive services that are delivered to the sick and disabled in their own homes. The services in a well-rounded home health agency include: nursing, physical therapy, occupational therapy, speech therapy, homemaker home health aide services, medical social work, nutritional guidance, and volunteer services. Home health service facilitates rehabilitation, hastens recovery from illness, maintenance of health and preservation of human dignity in life and throughout the dying process.

Those of us who are engaged in providing health care to individuals in their homes have long recognized both the cost-effectiveness and the appropriateness of this delivery system for many individuals who might otherwise be sent to institutions.

An example of the cost-effectiveness of home health care is illustrated in a study prepared by the Visiting Nurse Association and Blue Cross of St. Louis, Missouri (see Appendix 1). This study, based on 224 patients referred by Blue Cross to the St. Louis VNA, estimated that, on the average, $3000 per patient in hospital costs were saved because of the referral to the VNA and the subsequent provision of home care. Other Blue Cross reports from Virginia and Maryland and other reports in the literature also document the net health care savings that can be achieved by the use of home care. Appendix 1 provides you and the Committee with a list of references to this report.

Cost savings are important, because we are all acutely aware that governmental spending for health care services and programs has been increasing at an alarming and increasingly unacceptable rate. The most recent statistics on national health expenditures published by the Health Care Financing Administration (HCFA) provide striking documentation. Overall spending for health care in the United States in 1980 totaled an estimated $247 billion, or about 9.4 percent of the gross national product. For Medicare and Medicaid alone, spending in 1980 amounted to $60.6 billion, of which $35.8 billion was for hospital care.

More significant has been the rate of increase in federal spending for health care services which, during the period between 1965-1979, averaged 18.6 percent annually. In fact, this growth rate cannot be sustained within the public resources which are projected to be available in future years.

Growth in Medicare payments for home health services has been significant as well. Much of the increased cost is due to increased unnecessary paperwork (see Attachment 2). Home health costs in fiscal year 1980 were $750 million, compared to $60 million for such services by Medicare in fiscal year 1968. Even so, the 1980 spending level represents less than 2 percent of Medicare outlays. Despite the growth in home health care spending and in the number of agencies providing such services, over 600 of the 3,105 counties in the United States are still without a certified home health agency. Most of these are rural areas with widely dispersed populations. Moreover, the growth in the over sixty-five population and, more importantly, growth in the over seventy-five age group portends an increasing demand for home health care services.

To sum up these observations, Mr. Chairman, we want to emphasize that appropriate and accessible home services must be provided if we are to avoid the costly and very often inappropriate institutionalization of many disabled or chronically ill individuals.

The Congressional Budget Office estimates that only 300,000 to 500,000 adults can be served by personnel from existing home health care providers, while 1.7 to 2.7 million adults have a need for home care. In addition, according to the CBO, 20-40% of nursing home patients could be cared for adequately without institutionalization if sufficient home health care were available.*

Since less than 2% of the Medicare or Medicaid dollar goes to home care, cost reduction in this area will result in relatively little impact on the budget. This Association is aware, however, that the federal budget must be reduced. Therefore, we are responding only to the areas which would seriously effect the delivery of home health care.

C. Proposed Cuts and Concerns

"REQUIRE MINIMUM COINSURANCE ON HOME HEALTH SERVICES UNDER MEDICARE."

The proposed budget includes the following explanation: "effect of legislation which would introduce coinsurance in home health services. Currently, no coinsurance is required of Medicare beneficiaries who use these services. Our proposal would require 5 percent coinsurance for all home visits. This small increase in cost-sharing is reasonable and should not deter the use of necessary home health services. However, it should act as a deterrent to unnecessary utilization. A recent General Accounting Office (GAO) audit, for example, found that 27 percent of home health visits covered by Medicare were questionable. Federal savings from this initiative would be $35 million in 1983."

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* Budget Issue Paper, Long-Term Care for the Elderly and Disabled, Congressional Budget Office, February 1977, page x.

The validity of the projected $35 million in 1983 is absurd.

1. The only decrease in utilization would be the lower income patient who may, of necessity, have to spend the coinsurance money on food or medicine for survival. Thus, putting the individual at risk for higher cost institutional care.

2. The coinsurance would amount to an average of only $2 per visit or approximately $12-$15 per month. There would be a substantial effect on the agency billing operation as all Medicare patients would have two bills rather than one. Thus, increasing the cost of administration (bill production, maintenance of two accounts receivable, mailing, collection, etc.)

3. Coinsurance, in many instances would be paid by Medicaid, therefore, increasing Medicaid costs.

4. A substantial minority of patients who could conceivably eke the co-payment out of their meager pensions would simply not pay the coinsurance, as was the case when coinsurance was required in prior years. If agencies are reimbursed for their bad debts related to coinsurance this further reduces savings. If they are not, this will put all honest providers out of business with the exception of those who have charitable contributions and official agencies. The preparer of the above proposal utilized data from the GAO Report. However, they failed to mention that the only agencies reviewed by the GAO for this report were agencies who had high home health aide utilization rates. Therefore, generalization can not be made from this study.

"ELIMINATE WAIVER OF PROVIDER LIABILITY FOR UNCOVERED MEDICARE SERVICES."

Proposal: "currently, payment is made to an institutional provider of services under Medicare for certain uncovered or medically unnecessary services furnished to an individual if the provider could not have known that payment would be disallowed for these items or services. Hospitals, skilled nursing homes, and home health agencies are presumed to have acted in good faith if their total denial rate on Medicare claims is less than certain prescribed levels. However, by paying for these servic Medicare has been spending money for items and services not considered reasonable and necessary. This proposal would eliminate the waiver of liability provision for providers. Federal savings from this initiative would be $10 million in 1983."

1. The basic assumption is incorrect. Medicare pays under the waiver for service that in the judgement of the intermediary is not medically necessary. The payment is made only if historically the intermediary agreed with the judgement of the provider in over 97.5% of all visits (from home health) the provider was correct. If the service was denied by the intermediary as a result of the patient not being home bound, not having doctor's orders, or any other technical reason the visits are not paid by waiver. Being 97.5% correct in judgement involving Medicare is indeed an art and not a science due to consistency in interpreting the regulations by intermediaries The Health Care Financing Administration (HCFA) does not utilize any scientific methodology in evaluating the intermediary relative to their ability to make correct claims determinations. Our Association has requested that intermediary reliability and validity in claims determination be part of the evaluation process. We were so concerned relative to the process, I developed an evaluation model that was submitted to HCFA and subsequently ignored (Appendix 3). The institution of such an

intermediary evaluation model could indeed save far more than the projected $10 million in the proposal if inappropriate claims are being paid. It is impossible under even the clearest regulations for a provider to be 100% correct in all of its judgements all of the time. None of us, you nor I, are 100% correct in our judgements all the time. Would it be fair for the citizens of the United States to pro-rate your compensation on judgements which they felt were not correct? If this proposal were initiated many agencies would go out of business due to the nature of the cost based reimbursement system; thus, leaving patients fewer alternatives to more expensive institutional care.

2. The implementation of this practice would require the agencies to bill Medicaid for denied services or to use funds earmarked for care of indigent patients. There would be a tendency in some agencies that do not have funds for indigent care to decrease utilization of home care out of fear that the needed visits would be denied with a subsequent increase in utilization of institutional care by the patient.

3. A line item cost could conceivably be reduced, however, it would be a subsequent bottom line increase in Medicare costs as a result of increased utilization of higher cost individual care.

CHANGES IN SUPPLEMENTAL SECURITY INCOME ELIGIBILITY.

"The following legislative proposals are included in the 1983 budget for SSI:

- Prorate the first month's benefit payment for new SSI recipients based upon the date of application;

- Round the maximum monthly SSI payment and actual benefit amount to the next lower dollar;

- Change the definition of disability to require a 24-month, rather than a 120 month prognosis; (minimum period predicted for duration of disabling condition);

- Give added emphasis to medical factors in determining whether an applicant for SSI benefits is disabled;

- Eliminate the initial $20 disregard of income for all new recipients coming on the rolls after January 1, 1983; and,

- Permit the recovery of SSI overpayments from other SSA-administered programs (Black Lung and OASDI benefits).

The total savings from these and other technical changes is estimated to be $78 million in 1982 and $256 million in 1983."

1. The assumption of cost savings as a result of this proposal may, on the surface, be true as Medicare and Medicaid rolls would be decreased temporarily. The fallacy of the assumption is in not looking at the longer term (6 months) effect of these cuts as these persons may delay health care until they deteriorate to the extent that their financial situation is effected; thus, entitlement to Medicaid at a time when the cost of care is going to be greater as a result of advances of the disease or deterioration process.

If this Committee is really serious, and I believe it is, in wanting to trim dollars from the budget without adversely effecting the elderly and disabled we propose:

1. Decrease unnecessary paperwork and duplication of effort by changing regulations which could result in a 20-30% ($150 million minimum) cost savings in home care. The national associations have repeatedly made recommendations for regulatory change which would not effect quality adversely but it would increase efficiency and decrease costs. One such request is attached (Appendix 2). The cost savings of this proposal would not effect home health care negatively as would other proposals yet it would save more than the proposed $81 million savings.

2. Consider the effect of any changes on the whole health care systems as changes in one area of health care can positively or negatively effect other components. Taken out of context the proposal sound good, however, when one looks at the entire system one realizes that the assumptions are invalid.

Thank you for the opportunity to present our views. We look forward to working with you and we stand ready to assist you in any way you deem necessary.

APPENDIX 1

Health Review

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VNA Study of Blue Cross Referrals Found Use of Home Care Saved Over $3,000 Per Patient.

Home Care for Blue Cross Insured Patients: A Case Study Reprinted from Home Health Review, Volume III, Number 4, December, 1980.

Home Care for Blue Cross Insured Patients: A Case Study

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For many years, home health care proponents have claimed that home health care represented not only an appropriate and humane mode of treatment, but also could afford an actual dollar savings in total health care costs. Home health care is defined as the delivery of part-time skilled nursing and other specialized services, as prescribed by a physician, in the patient's home.

In 1979, the Visiting Nurse Association of Greater St. Louis, with cooperation from the St. Louis Blue Cross, conducted a case study of Blue Cross-covered patients receiving VNA home health services. The study indicates that the use of home health care to shorten or delay hospitalization does result in significant dollar savings.

Presented here is the report of that case study, as published in the December, 1980 issue of *Home Health Review*, the *Journal of the National Association of Home Health Agencies*, and reprinted with its permission.

Nancy J. Berry, MHA
Susan L. Pettit, MPA

Home Care for Blue Cross Insured Patients: A Case Study

Overview

In the spring of 1980, the Visiting Nurse Association of Greater St. Louis (VNA), in cooperation with Blue Cross — St. Louis (Blue Cross), conducted a study of all Blue Cross insured patients admitted to VNA during 1979. The purpose of this study was to develop a valid data base for estimating:

1. The number and characteristics of Blue Cross enrollees who could benefit from utilization of Home Health Care;
2. The potential effect of such utilization on cost of care; and,
3. The potential effect of such utilization on providers of health care (hospitals, nursing homes, Home Care Agencies).

The data compiled for 1979 indicated that Blue Cross enrollees utilizing Home Care differ sharply from the larger population of Blue Cross enrollees admitted to hospitals. Although methodology for estimating optimal utilization is scarce, it appears that Home Care is grossly underutilized by Blue Cross enrollees.

The most dramatic finding of this study is the impressive cost savings which were apparently realized due to the utilization of Home Care. This finding is based on estimates provided by the admitting physician for each patient and is, therefore, quite subjective. However, while the magnitude of the savings may be somewhat inflated, the conclusion that savings were indeed realized for a large majority of patients appears to be indisputable. The admitting physicians for 85% of the patients for whom physician responses were received believed that Home Care had been substituted for additional care in an inpatient setting. When the average cost per day for hospital care was applied to the estimated number of days saved, the savings to Blue Cross after deducting the actual cost of Home Care averaged $4,000 per patient. When patients whose Home Care was in addition to, rather than in lieu of, hospital care are included, the average per patient savings is still $3,336. No attempt was made to estimate additional savings realized due to decreased utilization of long-term care facilities, so the actual reduction in total cost of care was undoubtedly greater.

While the impact of the increased utilization of Home Care by Blue Cross subscribers could be significant to Home Care Agencies and to total Blue Cross costs, the relatively small numbers of patients involved in any single hospital or nursing home would probably cause the impact to be negligible to that institution.

Methodology

A total of 244 admissions to VNA in 1979 listed Blue Cross as payment source. Seventeen of those patients were still being seen at the time data was collected and were, therefore, excluded from the analysis. Three additional patients were excluded due to incomplete data. Of the remaining 224 admissions included in the analysis, 30 were the second admission for that patient during 1979. Therefore, although data was compiled for 224 admissions, there were only 194 unduplicated patients.

The data collected by VNA on each of these patients included primary diagnosis, the number of Home Care visits by discipline, days on service, patient age, and hospital length of stay. Blue Cross provided comparable data for all Blue Cross patients admitted to St. Louis area hospitals in 1979. The Blue Cross data included the number of admissions by age and diagnosis, the overall average length of stay, the average length of stay by diagnosis, and repeat hospital admissions by diagnosis.

The third major source of data was the physicians who had referred the Blue Cross patients to VNA. Each physician received a letter from VNA which identified the patient by name, diagnosis, number of Home Care visits by discipline, the patient's hospital and length of hospitalization. The physician was asked to provide the following estimates of the impact of VNA services for his/her patient:

- allowed early discharge from hospital, saving approximately __________ inpatient days.
- prevented rehospitalization, saving approximately __________ inpatient days.
- delayed rehospitalization, saving approximately __________ inpatient days.
- prevented admission to skilled nursing facility.
- prevented admission to other extended care facility.
- did not affect utilization of other health care resources.

Physicians returned questionnaires for 129 of the 194 patients for a 66% response rate. As there was no follow up to the questionnaire due to time constraints, this was considered to be a very good response. Of the 129 questionnaires returned, 114 were complete, including 16 which indicated no savings of inpatient care. An additional eight indicated that Home Health Services had replaced some inpatient services, but the physician did not estimate how many days had been saved. Seven questionnaires were returned without physician comment regarding impact on other health care resources.

Differences in Population Characteristics

The 224 Blue Cross admissions to VNA represented less than 0.3% of all Blue Cross hospital admissions of patients under 65 (84,250). As illustrated in Table 1, the age distribution of the two populations was very different. While one third of the patients admitted to VNA were in the 60-64 age group, only 13% of the admissions to hospitals were in this age range. The 21-49 age group accounted for 50% of the admissions to hospitals, but only 22% of the admissions to VNA.

Table 1: Distribution of Admissions by Age

Age Range	Blue Cross Admissions to VNA (n=224)	Blue Cross Admissions to Hospitals (n=84,250)
0-20	11%	17%
21-49	22%	50%
50-54	16%	9%
55-59	16%	11%
60-64	33%	13%
65+	2%	*
TOTAL	100%	100%

*Data on patients 65+ not available from Blue Cross.

Distribution by diagnosis of Blue Cross/VNA admissions is also very different from Blue Cross hospital admissions, as illustrated in Table 2. Patients are listed by primary diagnosis only, although most VNA patients have multiple and interrelated diagnoses. Of the four most frequent diagnostic categories for Blue Cross/VNA admissions, only one (Accidents, Poisonings and Violence) is also among the four most frequent categories for Blue Cross hospital admissions. The four largest categories for Blue Cross/VNA admissions represent 68% of all Blue Cross/VNA admissions but only 31% of Blue Cross hospital admissions.

Table 2: Distribution of Admissions by Diagnosis

ICDA Categories	Blue Cross Admissions to VNA (n=224)	Blue Cross Admissions to Hospitals (n=84,250)*
Infective & Parasitic	<1%	1%
Neoplasms	26%	7%
Endocrine, Nutritional & Metabolic	11%	3%
Diseases of Blood & Blood-Forming Organs	1%	<1%
Mental Disorders	<1%	6%
Diseases of Nervous System & Sense Organs	4%	5%
Diseases of Circulatory System	17%	9%
Diseases of Respiratory System	6%	7%
Diseases of Digestive System	4%	14%
Diseases of Genitourinary System	2%	11%
Complications of Pregnancy, etc.	—	11%
Diseases of Skin & Subcutaneous Tissues	2%	1%
Diseases of Musculo-Skeletal System	5%	6%
Congenital Anomalies	2%	<1%
Perinatal Morbidity & Mortality	2%	<1%
Symptoms & Ill-Defined Cond.	2%	5%
Accidents, Poisonings & Violence	14%	12%

*Excluding patients 65+

Table 3 allows comparison by age within the four most frequent diagnostic categories for Blue Cross Home Care patients. Generally speaking, older persons make up a greater proportion of Home Care patients in each of these categories than is typical for hospital admissions.

Table 3: Distribution of Admissions by Age for Most Frequent Home Care Diagnostic Categories

Blue Cross Admissions to VNA

ICDA Category	Age						No. of Admissions
	0-20	21-49	50-54	55-59	60-64	65+	
Neoplasms	—	15%	24%	22%	39%	—	59

Blue Cross Admissions to VNA

ICDA Category	Age 0-20	21-49	50-54	55-59	60-64	65+	No. of Admissions
Circulatory	–	13%	13%	16%	55%	3%	38
Accidents, etc.	22%	22%	11%	16%	26%	3%	31
Endocrine, etc.	12%	28%	4%	16%	40%	—	25
All Categories	11%	22%	16%	16%	33%	2%	224

Blue Cross Hospital Admissions

ICDA Category	0-20	21-49	50-54	55-59	60-64	65+	No. of Admissions
Neoplasms	6%	37%	16%	20%	21%	*	5.996
Circulatory	4%	36%	17%	20%	23%	*	7.899
Accidents, etc.	27%	37%	8%	11%	17%	*	9.695
Endocrine, etc.	12%	50%	13%	14%	11%	*	2.241
All Categories	17%	50%	9%	11%	13%	*	84.250

*Data on patients 65+ not available from Blue Cross.

Admissions by Prior Hospital Length of Stay

Blue Cross coverage of Home Care requires a prior hospital stay; therefore, each of the Blue Cross Home Care admissions followed an inpatient episode. The average length of stay (LOS) in the hospital for Blue Cross patients subsequently admitted to VNA was 24.1 days. This is a dramatically different experience than the 7.6 days average LOS for all Blue Cross hospital admissions. As illustrated in Tables 4 and 5, this difference in length of inpatient stay was consistent through all diagnostic and age categories. Even when allowances are made for the effect of extreme values which may skew the average (mean) LOS, the difference continues to be dramatic. For example, the median hospital LOS for Blue Cross Home Care patients is 18 days. This large discrepancy suggests that the Blue Cross patients referred to VNA for Home Care Services are much more acutely ill or are patients with more complicated diagnoses than the average Blue Cross admission to St. Louis hospitals.

Table 4: Mean Length of Hospital Stay by Diagnosis

ICDA Categories	Blue Cross Admissions to VNA	Blue Cross Admissions to Hospitals
Infective & Parasitic	NA	6.9
Neoplasms	22.1	9.7
Endocrine, Nutritional & Metabolic	17.1	8.7
Diseases of Blood & Blood-Forming Organs	19.5	6.2
Mental Disorders	NA	19.9
Diseases of Nervous System & Sense Organs	17.5	5.7

Table 4: Mean Length of Hospital Stay by Diagnosis

ICDA Categories	Blue Cross Admissions to VNA	Blue Cross Admissions to Hospitals
Diseases of Circulatory System	26.1	9.4
Diseases of Respiratory System	23.6	5.3
Diseases of Digestive System	20.6	7.0
Diseases of Genitourinary System	18.5	5.5
Complications of Pregnancy, etc.	0	4.5
Diseases of Skin & Subcutaneous Tissues	25.6	7.3
Diseases of Musculo-Skeletal System	25.7	8.3
Congenital Anomalies	34.0	7.5
Perinatal Morbidity & Mortality	95.8*	14.6
Symptoms & Ill-Defined Condition	17.0	11.7
Accidents, Poisoning & Violence	24.6	4.4
Overall Mean LOS	24.1	7.6

*Skewed by one extreme value (303 days). If that value were excluded, mean LOS would be 44 days.

Table 5: Mean Length of Hospital Stay by Age

Age Ranges	Blue Cross Admissions to VNA	Blue Cross Admissions to Hospitals
0-20	34.7*	5.6
21-49	22.2	7.1
50-54	27.5	8.7
55-59	22.3	9.3
60-64	23.6	9.6
65+	15.2	**
Overall Mean LOS	24.1	7.6

*Skewed by one extreme value (303 days). If that value were excluded, mean LOS would be 23.0 days.

**Data on patients 65+ not available from Blue Cross.

Utilization

As shown in Tables 6 and 7, the mean number of Home Health visits made to each Blue Cross patient admitted to VNA was 13.1 with a median of seven visits. The difference between the mean and median values is due to a few cases with extremely high numbers of visits. Blue Cross patients, as a group, use fewer visits than the general VNA population, which averaged 22.4 visits per admission during 1979.

Table 6: Home Care Visits/Admission by Diagnosis

	Number of Home Care Visits			
ICDA Categories	Mean	Median	Range	Number of Admissions
Infective & Parasitic	17	*	*	1
Neoplasms	11.5	6	1-93	59
Endocrine, Nutr. & Metabolic	12.7	6	1-114	25
Diseases of Blood & Blood-Forming Organs	14.5	*	12-17	2
Mental Disorders	4	*	*	1
Diseases of Nervous System & Sense Organs	15.0	13	1-28	10
Diseases of Circulatory System	15.9	8.5	1-93	38
Diseases of Respiratory System	27.6	20	3-106	13
Diseases of Digestive System	10.8	9.5	2-28	10
Diseases of Genitourinary System	3.8	3.5	1-7	4
Diseases of Skin & Subcutaneous Tissues	7.4	4	1-24	5
Diseases of Musculo-Skeletal System	10.6	4	1-49	11
Congenital Anomalies	6.5	6	1-13	4
Perinatal Morbidity &	12.6	11	9-21	5
Symptoms & Ill-Defined Condition	5.8	2	1-12	5
Accidents, Poisoning & Violence	12.5	9	1-43	31
ALL BLUE CROSS ADMISSIONS	13.1	7	1-114	224

*Too few admissions to calculate values

Table 7: Home Care Visits/Admission by Age

	Number of Home Care Visits			
Age Category	Mean	Median	Range	Number of Admissions
0-20	7.6	5	1-21	25
21-49	14.3	10	1-93	50
50-54	16.1	10	1-93	35
55-59	12.1	6	1-114	37
60-64	13.6	8	1-106	73
65+	8.5	8	2-16	4
ALL BLUE CROSS ADMISSIONS	13.1	7	1-114	224

The lower level of utilization of services per admission by Blue Cross patients as compared to the general VNA population may be due in part to the younger age of the Blue Cross patient as well as limitations in coverage.

It is difficult to evaluate whether the current level of Blue Cross admissions to Home Care is appropriate due to the lack of widely accepted methodology. There is little argument that the under 65 population, which for the purposes of this study includes the Blue Cross subscribers, requires fewer Home Care Services than the 65 and over population group.

The State of Florida developed methodology which identifies two percent of non-Medicare hospital admissions as an appropriate level of Home Care utilization. The Gennessee Region Home Care Association of Rochester, New York, which coordinates most Blue Cross Home Care referrals in their area, estimates they receive approximately three percent of Blue Cross hospital discharges, excluding OB/GYN and mental health discharges. As Blue Cross of Rochester is among the most comprehensive Blue Cross programs for Home Health coverage, their experience may be both a desirable and achievable goal for other areas.

When each of these methodologies is applied to the 1979 Blue Cross hospital admissions in the St. Louis area, the "appropriate" utilization calculated by the Florida methodology is 1,432 referrals to Home Health Agencies while in Rochester approach calculates 1,793 referrals. (These figures were calculated using the 85% of Blue Cross 1979 hospital admissions estimated to reside in the VNA service area.)

During 1979, VNA received 73% of all Blue Cross referrals to Home Health Agencies. Therefore, total Blue Cross admissions to Home Health Agencies during the year were approximately 334. This is less than one half of one percent of Blue Cross hospital admissions and a far cry from the 1,400 to 1,800 referrals estimated to be appropriate using the methodologies listed above. Referrals would have to increase more than 500% to reach the referral rate experienced in the Rochester area.

Although the methodology employed is crude, the vast difference between the estimated appropriate utilization and the level of utilization in the St. Louis area strongly suggests that Home Health Services are significantly underutilized.

As stated earlier, the current level of Home Care referrals is such a small percentage of Blue Cross hospital admissions that the impact on any organization providing inpatient care is undoubtedly negligible. Even if Home Care utilization were to increase to the level experienced in Rochester, the number of patients involved in any single institution would still be quite small. However, while increased utilization of Home Care will certainly not empty hospitals and extended care facilities, it will relieve the pressure on facilities experiencing high occupancy rates. This, in turn, should decrease the perceived need to build additional inpatient beds. In this way, increased utilization of Home Care could further contribute to decreased total health care costs by helping to contain overhead costs.

Cost Effectiveness of Home Health Services

Based on physicians' responses to a questionnaire, utilization of Home Health Care had the following impact on utilization of other health care resources for 129 unduplicated Blue Cross patients:

— allowed early hospital discharge, prevented or delayed rehospitalization	92
— prevented admission to SNF or other ECF in addition to substituting for hospital days	52
— prevented admission to SNF or ECF without impacting length of hospitalization	14
— did not affect utilization of other health care resources	16
— no judgment by physician	7

Of the 66 patients who would have been admitted to a skilled nursing (SNF) or other extended care facility (ECF), 23 were marked as potential SNF admissions, 15 as ECF admissions, and 28 for both levels of care.

Physicians for 84 of the patients believed to have substituted Home Care for additional hospital days were able to quantify their estimates of inpatient days saved. These physicians estimated that for these 84 patients Home Health Services actually saved 903.5 inpatient days by allowing for an early discharge from the hospital, 404.5 inpatient days by preventing rehospitalization, and 398.5 inpatient days by delaying rehospitalization.

In the opinion of these physicians, these 84 Blue Cross patients admitted to VNA in 1979 saved a total of 1706.5 inpatient days which would have been utilized in the absence of Home Health Care.

In 1979, Blue Cross — St. Louis estimated that its average cost per day for hospital care was $220.51. When this amount is multiplied by 1706.5 patient days, the total cost of savings for these 84 patients is $376,300.32.

In order to calculate the net savings for these patients, the number and cost of Home Care visits made to the 84 patients must be deducted from gross savings. The following visits were made by VNA to the 84 patients:

831	Skilled Nursing
204	Physical Therapy
63	Speech Pathology
45	Occupational Therapy
4	Nutrition
19	Medical Social Service
63	Home Health Aide
1,229	TOTAL VISITS

The average cost of a professional visit (all visits other than Home Health Aide) was $33.00 in 1979. The total cost of the professional visits made to the 84 Blue Cross patients was $38,478 (1,166 visits X $33.00). The cost of a nonprofessional or Home Health Aide visit for VNA in 1979 was $23.50. Therefore, the cost for Home Health Aide visits made to these 84 Blue Cross patients was $1,480.50 (63 visits X $23.50) The total cost of providing 1,229 visits to these 84 Blue Cross patients in 1979 was $35,484.87. When this amount is deducted from the amount saved by substituting Home Care for 1,706.5 inpatient days ($376,300.32), an estimated $336,341.82 was saved by utilizing Home Health Services in lieu of hospital care. This is over one-third of a million dollars in savings to Blue Cross for [illegible] 84 patients [illegible] an average $4,004.07 per patient.

In all fairness, any discussion of net savings per patient should consider those patients for whom Home Health Services did not replace inpatient care and were, therefore, an [illegible]. The 16 patients who received Home [illegible] without reducing their use of inpatient facilities used 84 professional Home Health visits and no Home Health Aide visits. These 84 visits cost $2,772 (84 x $33.00). Therefore, when these 16 patients [illegible] with the 84 patients who experienced savings, the total net savings is reduced to $333,569.32 or an average of $3,335.70 for each of the 100 patients.

Even if these estimates are inflated, the magnitude of the estimated savings and the large percentage of Home Care patients for whom Home Care replaced institutionalization indicate it is in Blue Cross' self-interest, as well as the patient/consumer's interest, to encourage utilization of Home Care.

Conclusions

1. The Blue Cross beneficiaries currently utilizing Home Care appear to be a subgroup of the broader Blue Cross population. They are generally older, have longer inpatient stays, and represent a disproportionately large number of primary diagnoses of neoplasm, circulatory disease, and metabolic disease. Perhaps as many as five times the number of Blue Cross patients currently receiving Home Care could benefit from it.
2. The vast majority of physicians referring Blue Cross patients to VNA believe that significant savings in total cost of care is achieved. The 100 patients for whom physicians estimated the number of hospital days saved, including patients with no savings, accounted for an estimated net savings of $333,570. If these patients are representative of the remaining patients whose physicians did not respond or did not complete the questionnaire, utilization of VNA may have saved Blue Cross patients more than half a million dollars in 1979 alone. If the potential appropriate utilization is four to five times the current utilization, the possible annual savings to Blue Cross and the community is staggering. The conclusion is reinforced by the fact that additional economies are occurring but not quantified in the area of skilled nursing and other extended care facilities.
3. Increased utilization of Home Care would obviously be beneficial to Home Care Agencies, but it would also relieve overcrowding of both acute care and long term care inpatient facilities. If this prevents building additional beds, the entire health care system and community will share the savings, while inpatient facilities will be able to better serve those patients requiring the more intense services appropriate to institutional care.

Although additional efforts are needed to improve the techniques used to estimate appropriate utilization, calculate actual savings realized, and estimate the extent to which Home Care is substituted for inpatient care, this study unquestionably supports the contention that Home Care Agencies have believed for years. Increased utilization of and expenditures for Home Health Care result in decreased total expenditures for health care.

APPENDIX B

References

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APPENDIX 2

Form Approved
OMB No. 0938-0169

HCFA Task Force for Regulatory Reform

This format has been developed by the HCFA Task Force for Regulatory Reform. Responses will be used to determine which HCFA regulations should be considered as candidates for revision or deletion. Include as much information as possible. Please use a separate form for each regulation.

1. State the subject of the existing regulation and the regulatory citation (if known):

   See attachment I -- It is unclear as to whether intermediaries are within their statutory or regulatory right to demand any information they deem necessary in claim determinations.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   It was designed to facilitate the decision for Home Health coverage by intermediaries. In essence it accomplishes that task; however, it is a very costly process.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   The cost burden of complying with this request is greater than the effect. If certain information is necessary for intermediary to make a decision, the information should be delineated. All intermediaries should then ask for the same information. Intermediaries are not required to meet standard educational, skill, knowledge, experience requirements; therefore, staff vary in their understanding of Medicare regulations and Home Health practice and their ability to administer the Home Health benefit in an accountable manner to the beneficiary.

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

Predetermination of information which is necessary to make claims determination for all intermediaries and minimum staff qualifications to be developed by a panel of expert providers and HCFA officials.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Gives the intermediary too much discretion. An intermediary may compensate for its staff's inadequacies in requiring unnecessary information and explanations from providers.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

The existance of this practice is conservatively estimated at over $2.00 per visit in administrative costs and an untold amount in opportunity cost for both the provider and intermediary.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

Yes -- see attachment.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Revision -- high priority. See attached.

ADDITIONAL COMMENTS:

Summary

In order to be reimbursed for Home Health Care by Medicare, one must:

1. Submit a Start of Care SSA-1487-A when patient is admitted to service (see blue attachment).

2. Submit a Home Health Agency Billing HCFA-1487c on a monthly basis

As one readily sees, there are sixteen items on the HCFA which must be completed monthly which have been completed on the SSA-1487-A when the patient was admitted to service (twelve of which are unchanging items and four of which rarely change)

Additionally,

The fiscal intermediary may require any information it deems necessary in making a decision as to whether the care is covered. (It is interesting to note that virtually every intermediary in the country has a different requirement for information, all of whom are supposed to bemaking determinations using the same regulations).

The intermediary serving VNA of Metro Atlanta, BC/BS of Atlanta also serves many other Home Health Agencies in Georgia, in addition to the SSA-1487-A and the HCFA-1487c they require:

1. A copy of the Plan of Treatment (including doctor's orders) and interim doctor's orders.

2. A Home Health Nursing Information form - compiled monthly.

These four items require that four items be duplicated four times - one time on admission, one time every 60 days and two times every month thereafter. They further require that nine items be duplicated three times, etc. (refer to attached grid). Furthermore, the intermediary may ask for copies, if clinical notes, etc. at will. There were more items of duplication until the providers in the area worked with the intermediary in decreasing some duplication.

The conditions of participation further require:

1. A Plan of Treatment at least every 60 days.

2. A Summary Report to the physician and other appropriate provider at least every 60 days.

In looking at the grid, it is evident that much duplication is present.

If five or six very knowledgeable persons representing providers and governmental agencies could meet in order that they might identify the kind of information necessary to provide quality care and for intermediary to make "covered care" decisions, perhaps new forms could be developed which would eliminate some duplication.

The forms which I have attached are but a few possibilities for change. I suggest that they could serve as a starting point. Please bear in mind that I do not think that these forms are finished products and much consideration must be given to any final product.

-80/VNA, Atlanta

			ORDERS	NOTES DOCUMENT EACH VISIT
NUMBER OF FREQUENCY OF VISITS EA. SERVICE	X	X	X	
ACTUAL CHARGES	X			
DESCRIPTION OF SERVICES PROVIDED		X	X	
PROGNOSIS			X	
MENTAL STATUS			X	
DIET			X	
SAFETY MEASURES			X	
ACTIVITY PERMITTED			X	
SUPPLIES			X	—
FUNCTIONAL LIMITATIONS			X	
REHAB. POTENTIAL			X	
HOMEBOUND STATUS AND REASON			X	X
MEDICATIONS			X	
DRUG ALLERGIES			X	
[illegible] GOALS			X	

[illegible]

LOCATION OF INFO.	START OF CARE	BILL	NIF	PLAN OF TREATMENT	ADDITIONAL INFO
FREQUENCY SUBMITTED	1X/ONLY	MONTHLY	MONTHLY	EVERY OTHER MONTH	AS REQUESTED
ITEMS					
HIC NUMBER	X	X	X		
PT. ADDRESS	X	X		X	
DATE OF BIRTH/AGE	X	X	X	X	
SEX	X	X		X	
HHA NAME & ADDRESS	X	X	X	X	
PROVIDER NUMBER	X.	X	X		
MED. RECORD NO.	X	X			
MD NAME & ADDRESS	X	X		X	
DATE CARE STARTED	X	X	X		
NAME OF HOSP./ECF	X	X			
HOSP./ECF DATES	X	X			
DATE HOME HEALTH PLAN ESTABLISHED	X	X			
PAYMENT SOURCE FOR CHARGES TO PT.	X	X			
AUTHORIZATION (ON FILE)	X	X			
DIAGNOSES	X	X		X	
PERIOD COVERED BY STATEMENT		X	X	X	
PT.: ACTIVE, DISCHARGED, VS. EXHAUSTED, DIED, VS. EXHAUSTED		X			

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OMB No. 0938-0169

HCFA Task Force for Regulatory Reform

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1. State the subject of the existing regulation and the regulatory citation (if known):

   206.1 Coverage of Medical Social Services.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   No; regulation is too vague.
   Clearly define and give example of covered medical Social Services which contribute meaningfully to the patients medically related social needs.
   eg. Assist patient with nursing home placement.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Yes - More medical Social Services are needed for many of our homebound skilled Home Health patients.

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

    Less restrictive regulation.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

    Regulation unclear and restrictive.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

    Yes.
    Pending and lingering unsolved social problems often lead to costly institutionalization.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

   Not Applicable.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

   Revise to cover more social services.

ADDITIONAL COMMENTS:

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1. State the subject of the existing regulation and the regulatory citation (if known):

None existing.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

Yes -- Home Health agency owners or operators may leave one Home Health agency (selling, being fired, etc.) and open new Home Health agencies. Many have left another agency under adverse conditions, such as misappropriation of funds, owing Medicare, not paying unemployment insurance, and not paying creditors or employees.

HCFA-285

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

The bonding requirement be invoked in all cases in which the principals or administrators owned or own a health care entity with outstanding obligations to HCFA.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Definitive parameters be developed delineating those circumstances under which a bond be required to preclude the utilization of this practice as a retaliatory measure by Fiscal Intermediaries.

ADDITIONAL COMMENTS:

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1. State the subject of the existing regulation and the regulatory citation (if known):

   HIM 11; 205 - Coverage of Speech Therapy and Occupational Therapy.

   Conditions of Participation 405.1225

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   Provision for Speech Therapy and Occupational Therapy is not included.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Expand upon regulations to specify coverage guidelines for Speech Therapy and Occupational Therapy.

HCFA-285

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

Not applicable.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Yes.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

No.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

Not applicable.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Add a complete section on Occupational Therapist and Speech Therapy coverage. Give examples to the extent of coverage for a given diagnosis.

eg. Stroke patients; certain neurological diseases; receptive and expressive aphasia.

ADDITIONAL COMMENTS:

Do not have the expertise to compile the guidelines. Please consult Occupational Therapy and Speech Therapy national associations. HCFA and national associations should develop definitive parameters under which services will be covered.

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1. State the subject of the existing regulation and the regulatory citation (if known):

   Conditions of participation and HIM 15.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   The conditions of participation were designed to ensure minimum standards for participating agency's performance and HIM 15 was supposedly designed to outline a reimbursement mechanism. Each does what it was designed to do .... however, they conflict with each other.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Eliminate HIM 15.

   Revamp reimbursement system.

HCFA-285

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

Same as #3.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Conditions of Participation conflicts with HIM 15.

Conditions of Participation requires certain levels of quality which HIM 15 or auditors disallow -- costs related to items such as "treating total patient," discharge planning, etc.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Not applicable.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Revise in order that all practices required are indeed reimburseable.

ADDITIONAL COMMENTS:

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1. State the subject of the existing regulation and the regulatory citation (if known):

   Reg. 204.51 - Intravenous and hypodermociyisis feedings.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   Regulation, as it reads, encourages institutionalization.

   Denies those patients needing I.V. feedings in the terminal stages to die at home.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Yes.

   Regulation needed to allow for coverage of hospice home care.

HCFA-285

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

Reimbursement for care needed to maintain persons at home.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Regulation is too restrictive.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Yes -- mandates institutionalization.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

Not applicable.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Revise regulation to reflect the current state of the art and accepted medical and nursing practices.

ADDITIONAL COMMENTS:

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1. State the subject of the existing regulation and the regulatory citation (if known):

   Prior to 1979, front end approval for Medicare claims was working well. We are experiencing problems with coverage issues and would like to see this practice reinstated.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   Not applicable.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Yes, because a provider may not know if care is covered until after care is delivered. A provider cannot predict the decision which will be made by Fiscal Intermediaries due to inconsistency. Likewise, the beneficiary suffers frustration due to untimeliness of decision.

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

   . Resume front end coverage.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

   Home Health coverage should be given same priority as hospital and/or skilled nursing facility coverage.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

   Yes -- due to inconsistency of decisions made in Home Care and duplication of documentation.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

. Yes.

Forwarding of multiple documents for proof that criteria for admission has been met is costly to agencies.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Reinstate practice of front end review and quarterly random sampling in the field.

ADDITIONAL COMMENTS:

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1. State the subject of the existing regulation and the regulatory citation (if known):

   HIM 11; 240.3, 208.3 - Physician Recertification.

   Conditions of Participation 405.1223B

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   A complete profile of patient's condition, treatment, etc. is forwarded to the physician every 60 days to justify need for Home Health Care and to obtain continuing orders for care.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Regulation as it now reads -- increases undue paper work.

HCFA-285

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

Require a complete plan of treatment on each patient at the end of the first 60 days of service. Thereafter, require a shortened version on a 90 day basis. This shortened version would require that only change or addition be noted.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Regulation of this activity is necessary, but at present it is duplicative and unnecessary.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Yes -- increased cost incurred from additional paper work to prepare detailed recertification every 60 days resulting in both agency personnel and physician spending time unnecessarily in completion of this paper work.

Possible Replacement

Plan of Treatment
(Doctors Orders, Recertification, Treatment Plan)

1. Initial plan would be completed on admission.

2. Plan of Treatment - Recertification would be completed at least every 90 days (more frequently if necessary) thereafter. The short form would be affixed to the back of the initial plan (in the manner illustrated on attached forms) thus enabling a year's orders and recertification to be examined by looking at one page.

Visiting Nurse
Association
of Metro Atlanta

[illegible] Cheshire Bridge Road, N.E.
Atlanta, Georgia 30324
Telephone 404 / 873-2883

VNA

Initial [illegible]

PLAN OF TREATMENT

PHYSICIAN:

PHONE:

ADDRESS:

NAME:

ADDRESS:

PHONE:

M/F B/D

HIC NO.

DIAGNOSIS:

DOES PATIENT KNOW DIAGNOSIS:

PROGNOSIS: ☐ Good ☐ Fair ☐ Poor ☐ Guarded ☐ Term

MENTAL STATUS: ☐ Alert ☐ Forgetful ☐ Confused ☐ Agitated ☐ Comatose ☐ Depressed

DIET:

SAFETY MEASURES:

ACTIVITIES PERMITTED:

SUPPLIES:

FUNCTIONAL LIMITATIONS:

REHABILITATION POTENTIAL:

HOMEBOUND: ☐ Yes ☐ No ☐ Reason:

SERVICES:	NURSING	PHYSICAL THERAPY	SPEECH THERAPY	OCCUPATIONAL THERAPY	MEDICAL SOC. SER.	H. H. AIDE-PER CAR
FREQUENCY:						
DURATION:						

SKILLED NURSING:

A. ☐ Skilled Observation (Inc. V.S., Med. Reaction, etc.)
B. ☐ Foley Irrigation Instruction
C. ☐ Foley Installation - Size____Fr.
D. ☐ Change Catheter - Size____Fr. Frequency______
E. ☐ Wound Care/Dressings Specify______
F. ☐ Decubitis Care
G. ☐ Teach. Special Diets Specify______
H. ☐ Teach Adm. of Insulin
I. ☐ Bowel/Bladder Training
J. ☐ Chest Physio. (Inc. Postural Drainage)
K. ☐ Adm. of Vitamin B-12
L. ☐ Teach. Diabetic Ca
M. ☐ Tech. Care of Terminally Ill or Bedridden Patient
N. ☐ Other Teach.

MEDICATIONS:

DRUG ALLERGIES: ☐ Yes ☐ No
SPECIFY:

TREATMENTS/ACTIVITIES:

PATIENT GOALS FOR NEXT 60 DAYS:

EFFECTIVE DATES:

From__________ To__________

☐ CERTIFICATION ☐ RECERTIFICATION: I certify that the above-named patient (1) is under my care, (2) is homebound except when receiving outpatient services, (3) requires skilled nursing care on an intermittent basis or physical or speech therapy as specified in the original orders with the modifications listed above.

____________________ __________
(Physician's Signature) (Date)

VNA/Acl 10/79
Copies: 1)Record 2)Physician
3)Guardian 4)Other

Plan of Treatment
Recertification

.NAME: ______________________ Birthdate ____________

ADDRESS: ______________________

☐ Changes in orders, plan of treatment or visit frequency as follows:

☐ Continue orders, plan of treatment and visit frequency as before

PATIENT GOALS FOR NEXT 60 DAYS:

EFFECTIVE DATES:

From ____________ To ____________

VNA/Acl 10/79

☐ CERTIFICATION ☐ RECERTIFICATION: I certify that the abov named patient (1) is under my care, (2) is homebound except whe receiving outpatient services, (3) requires skilled nursing care on a intermittent basis or physical or speech therapy as specified in th original orders with the modifications listed above.

____________ (Physician's Signature) ____________ (Date)

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1. State the subject of the existing regulation and the regulatory citation (if known):

204.2 - Reimburseable Skilled Nursing Care.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

Regulation implies who may render services deemed as skilled care. Allows for LPNs, LVNs to perform like skills of RNs.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

Change regulation to specify that:

1. Assessment visit be conducted by an RN; and,
2. If LPN is assigned to case, an RN visit should be made at least every 60 days.

HCFA-285

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

Revise regulation to assure RN intervention for each Home Health Care patient.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Too broad. In some cases violates nurse practice act.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Yes -- allows for breakdown in quality of care.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

Not applicable.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Yes -- see #4.

ADDITIONAL COMMENTS:

HCFA TASK FORCE FOR REGULATORY REFORM

HIM 15 - Interest expense - income

The regulation is designed to disallow interest expense to the extent of earned interest.

It is a disincentive for organizations to invest in other activities to accumulate capitol for the expansion of services. Artificially denies HCFA a true comparison of the costs of services.

Recommendation: Delete this section of HIM 15.

HCFA TASK FORCE FOR REGULATORY REFORM

HIM 15 - Accelerated Depreciation

Accelerated depreciation should be an allowable cost to the extent that it is allowed under IRS regulations. Straight line depreciation and periods of accelerated inflation is not representative of true costs. This policy encourages providers to lease equipment rather than purchase as lease expenses are an allowable cost during the period which the expense is incurred. It provides an additional burden on the cost as there is an interest expense for all lease agreements.

Recommendation: Depreciation expenses be identified to those allowable under IRS regulations.

HCFA TASK FORCE FOR REGULATORY REFORM

HIM 15 - Advertising

Advertising is a normal activity in any successful business. It allows for consumers to make a more intelligent choice.

Recommendation: Advertising be included as an allowable cost of Home Health Care providers.

HCFA TASK FORCE FOR REGULATORY REFORM

HIM 15 - Home Health Agency Coordinator

Reimbursement of Home Health Agency Coordination programs is being disallowed. Coordination functions are a needed Home Health Agency activity that must be allowable. Patients in need of Home Health services are being denied the benefit as the discharge planning function is not being carried out to include Home Care as an option at time of discharge.

Recommendation: Home Health Coordinator Care costs be allowable.

HCFA TASK FORCE FOR REGULATORY REFORM

HIM 15 - Grants, Gifts and Endowments

Grants, gifts and endowments that are designed for specific activities are deducted from allowable costs of operations. Artificially denies HCFA a true comparison of the costs of service.

Recommendation: Delete this section of HIM 15.

HCFA TASK FORCE FOR REGULATORY REFORM

HIM 15 - Reimbursement for Services

The methodology of reimbursement on a retroactive cost basis is one of the major reasons for accelerated increase of costs in the Home Care industry. Reimbursement as presently structured does, has and will contribute to the problems of fraud and abuse in this industry.

Recommendation: Strongly recommend that a prospective rate setting methodology for establishing maximum amounts of revenue based on allowable historical costs trended for inflation plus additions to costs over and above depreciation for additional financial needs - (i.e. profit incentive).

Payments to agencies need to be on a timely basis and not subject to retroactive cost denial due to regulation clarification or change.

There needs to be coordination between Federal and State reimbursement systems to include State insurance commissioners and commercial carriers.

The differential between Home Care charges paid by self-pay, the Blues and commercial carriers cannot be increased but, in fact, needs to be reduced.

The reimbursement mechanism greatly needs to be a system whereby all who use or pay for the service become responsible for their fair share of the fiscal burden of maintaining quality, adequate in-home services efficiently provided.

The time has passed for crisis and bandaid approaches to problems of this magnitude in the industry.

HCFA TASK FORCE FOR REGULATORY REFORM

"Intermediary Letters"

Home Health Agencies are being measured by standards promulgated by Intermediary Letters and delineated by the intermediary manual which may be totally unknown to the provider since netierh of the above cited directives are routinely disseminated to the Home Health Care provider.

Recommendation: All information contained in the Intermediary Letters and regulations should be incorporated into HIM 11 or HIM 15 within a stated time period. Sufficient lead time for implementation should be allowed to promote efficient management and retroactivity should never be a condition. regulations should be changed in order to comply with the Budget Reconciliation Act of 1980.

HCFA TASK FORCE FOR REGULATORY REFORM

HIM 15 - Return on Investment

Return on Investment is not an allowable cost for not-for-profit organizations providing Home Care services.

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OMB No. 0938-0169

HCFA Task Force for Regulatory Reform

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1. State the subject of the existing regulation and the regulatory citation (if known):

   Limitation on reasonable costs paid to therapist services provided by outside providers. Reg. 405.432

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   The regulation is designed to prevent excessive costs being incurred as a result of payment to suppliers of outside services (except physicians). Yes, and it also limits the amount of service that can be provided by outside suppliers.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Not for Home Health agencies. The Medicare cost caps for therapy services has eliminated the need for this regulation as it eliminates excess cost whether staff costs or outside supplier costs.

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

The current cost caps for home health could be expended in some for to other providers of therapy services.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

It is too detailed and duplicates the home health cost caps.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Yes. With the cost caps ther is no longer any benefit to home health agencies.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

No.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Delete the regualtion for home health agencies.

ADDITIONAL COMMENTS:

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OMB No. 0938-0169

HCFA Task Force for Regulatory Reform

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1. State the subject of the existing regulation and the regulatory citation (if known):

HIM 11; 204.4J - Coverage of Skin Care.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

Regulation prohibits coverage for appropriate measures.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

Yes -- regulation as it stands prohibits coverage of services needed to eliminate deteriorization in susceptable individuals.

HCFA-285

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

Change regulation to read: "Decubitus ulcers and skin disorders which necessitate skilled care, ordered by a physician will be covered."

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Not applicable.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Yes -- untreated skin problems in the home bound/bed bound elderly sick leads to greater problems which require increased man hours, medical supplies and equipment to treat. Often times leads to costly hospitalization.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

Not applicable.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Revise as stated. Provide for coverage of therapeutic skin care to eliminate deteriorization in susceptable individuals.

ADDITIONAL COMMENTS:

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HCFA Task Force for Regulatory Reform

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1. State the subject of the existing regulation and the regulatory citation (if known):

   HIM 11; 206.3C - Drugs and Biologicals.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   Regulation prohibits coverage of drugs for Home Health Care patients.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Yes -- change regulation to: "Those drugs (which are medically necessary) prescribed for patients while under the care of a Home Health agency will be covered."

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

Change regulations to cover drugs for Home Health patients.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Not applicable.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Yes -- non-coverage of necessary drugs prescribed for a patient while under the care of a Home Health Agency often leads to expensive institutionalization.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

   Not Applicable.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

   Change as stated.

ADDITIONAL COMMENTS:

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HCFA Task Force for Regulatory Reform

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1. State the subject of the existing regulation and the regulatory citation (if known):

   HIM 15; 15,2106 - Costs of telephone and televisions in patient rooms is a non-allowable cost.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   Eliminates costs of "personal comfort" items in patient rooms in hospitals and skilled nursing facilities.

   No -- the providers provide TV's and telephones in patient rooms on the presumption that it is rehabilitative and decreases the number of nurses required.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   No.

HCFA-285

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

None is required.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

The regulation is totally unnecessary!

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Yes -- auditors and hospital staff spend more time (and money) determining allowable and non-allowable proportions of telephone and television costs than on any single item in the average audit. The costs involved are well in excess of the cost of the systems which if they were not beneficial would have been eliminated long ago.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

Yes -- see section #6.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Deletion of this section.

ADDITIONAL COMMENTS:

In nursing homes that do not have central air conditioning, room air conditioners are personal comfort items and are non-reimburseable.

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1. State the subject of the existing regulation and the regulatory citation (if known):

   HIM 11; 218.3 - Home Health Agency Supervisory Visits

   Conditions of Participation 405.1227

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   Home Health Aide supervisory visits are counted as administrative costs to the agency.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Supervisory visits should be changeable visits, and should be made at the frequency deemed necessary by the agency. Criteria for deeming frequency of visits would be arrived at giving consideration to condition of patient — tenure of Home Health aide, etc.

What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

Change regulation to allow supervisory visits to be changeable visits.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Too restrictive as now stands.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Cost of every two weeks Home Health supervisory visit as overhead increases unit cost. Many times this visit is unnecessary. Supervision visits should be made at the descretion of the agency based on:

1. patient's condition;
2. Aides capabilities; and,
3. Aides tenure rather than an arbitrary time requirement of every two weeks.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

1. 15 Nurse minutes per Q 2 weeks per patient receiving Aide service.
2. Time and travel documentation for appropriate accounting.
3. Survey and audit time.
4. Scheduling time.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

To allow for:

1. charging for Home Health Agency supervisory visits as visits; and
2. scheduling visits at Agency's discretion.

ADDITIONAL COMMENTS:

This change could result in considerable cost savings.

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HCFA Task Force for Regulatory Reform

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1. State the subject of the existing regulation and the regulatory citation (if known):

   HIM 11; 218.3 - Evaluation Visits

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   The regulation lumps all costs for evaluation visits into the administrative costs.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Yes. There is an artificial inflation of administrative costs and an artificial decrease of the nursing function costs. There is a false perception in the community of what a service costs. It acts as a disincentive for physicians to utilize restorative media of Home Health.

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

To allow for charge of evaluation visits.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Not necessary

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Yes. Elimination of the regulation would eliminate costs involved in complying with the regulations. Would do away with the review process. Eliminate requirement for Fiscal Intermediary to review and audit. No significant total reimbursement change for a given agency however for the Medicare program costs should be reduced as a result of decreased intermediary activity.

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

An indemnity (or fee schedule) type of reimbursement for all services to beneficiaries. This would allow efficient providers to remain in the program, but would penalize providers with excessive costs.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

The regulations are not necessary.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Yes -- the regulations require external audits of all providers which is costly. The providers are required to maintain extensive records that would not otherwise be necessary. Compliance with the regulations requires that providers retain knowledgeable individuals in the area of Medicare costing.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

Significant paperwork and compliance burden. The burden is a separate accounting mechanism for evaluation visits, separate intermediary audit procedure, significant time explaining to the community and employees why this visit is treated differently.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Revision to make evaluation visits reimburseable as a unit of service.

ADDITIONAL COMMENTS:

Form Approved
OMB No. 0935-0169

HCFA Task Force for Regulatory Reform

This format has been developed by the HCFA Task Force for Regulatory Reform. Responses will be used to determine which HCFA regulations should be considered as candidates for revision or deletion. Include as much information as possible. Please use a separate form for each regulation.

1. State the subject of the existing regulation and the regulatory citation (if known):

   HIM 15; 405.401 - 405.488 - all providers of care; hospitals, skilled nursing facilities and Home Health Agencies are to be paid based on reasonable cost.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   The regulations are designed to reimburse the actual costs of the care provided. The regulations concerning costs do allow for a close approximation of provider costs.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Yes -- excessive costs relating the provision of health care. These regulations only serve to institutionalize the problems. The costs remain excessive, but providers and intermediaries spend an excessive amount of time and energy determining what is "reasonable" cost.

HCFA-285

Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

Yes -- the cost finding requires extensive data accumulation that would not otherwise be necessary. The elimination of the regulation is the only means of reducing paper work.

3. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Deletion of this section. Should be a major priority of the task force.

ADDITIONAL COMMENTS:

Form Approved
OMB No. 0935-0169

HCFA Task Force for Regulatory Reform

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1. State the subject of the existing regulation and the regulatory citation (if known):

   208.4 - Patient confined at home.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   Define population for which benefits are intended.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Problem exists due to intermediary interpretation of this regulation leading to denial of services to beneficiaries to which they are entitled without which rehospitalization and/or unnecessary and costly institutionalization may result.

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

Mandate intermediary compliance and regulation.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Yes it is necessary but unclear. Both inter and intra intermediaries interpretations tend to be inconsistent and/or restrictive.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

Yes -- when a patient is unfairly penalized by disallowing coverage leading to discharge or non-admission -- condition deteriorates leading to unnecessary institutionalization.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

Not applicable.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Top priority. To enforce compliance with intermediary.

ADDITIONAL COMMENTS:

Form Approved
OMB No. 0938-0169

HCFA Task Force for Regulatory Reform

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1. State the subject of the existing regulation and the regulatory citation (if known):

   205.2B - Coverage criteria for occupational therapist.

2. Provide your understanding of what this regulation does. Does it do what you think it was designed to do? If not, explain.

   No -- regulation does not provide for occupational therapist as a primary service.

3. Do you believe that a significant problem or policy objective currently exists which requires a regulatory solution? What is it? How well does this regulation resolve it?

   Policy objective cannot be met until occupational therapy is made a primary service.

HCFA-285

4. What alternative solutions (regulatory or otherwise) could better achieve the desired objective?

Add occupational therapy as a primary service with visit limitations -- to be determined by progress of patient as in physical therapy guidelines.

5. If you believe the regulation is necessary, is it clear? Is it too broad? Is it too detailed? Does it conflict with or duplicate other rules?

Regulation is necessary.

6. Does the cost of this regulation exceed the benefits? If so, explain in as much detail as possible.

No.

7. Does the rule impose a significant paperwork burden? If so, explain the burden and its extent. How can the paperwork burden be reduced and still achieve the regulatory purpose?

No.

8. Do you recommend deletion or revision of this regulation? If a revision is recommended, what specific changes would you suggest? What priority do you think the HCFA Task Force should assign to this regulation?

Retain occupational therapy as primary service as authorized in the Budget Reconciliation Act of 1980.

ADDITIONAL COMMENTS:

APPENDIX 3

PERFORMANCE EVALUATION
FISCAL INTERMEDIARIES

Area To Be Evaluated	Method	Rationale
Timeliness of denials.	Count the number of days from the time the claim is submitted (delivered to physical facility) until the day that the provider is notified that it is denied. Calculate: Mean, Median and Mode. Investigate: Discrepancies between mean and mode (therein lies severe problem area).	Present methods of measuring timeliness do not give an accurate picture, as extreme data is "thrown out", thus minimizing the skew. Present methodology is useless. Additionally, time of claims receipt is frequently calculated as the time the claim reached the claims department, rather than when the provider delivered it. Likewise, time recorded on the denial notification may vary significantly (4-10 days) from post mark on envelope in which denial was mailed. At the time calculations are made, there will be some outstanding claims for those that are older than the mean. Calculate the infinity rate as the longest time period lapsing between the submittal of a claim and its resolution during the last three years.
Timeliness of claims payment.	Count the number of days from the time the claim is submitted (delivered to the physical facility) until the provider is paid (date check mailed out of facility). Calculate: Mean, Median, and Mode. Investigate: Discrepancies between mean and mode (therein lies severe problem area).	

Consistency of coverage.	Reliability of determination should be tested on a statistically valid, random sample. Both Inter and Intra observed reliability should be tested blindly. Validity of tool or methodology for making determinations should be determined both in terms of sensitivity and specificity.	At present, the greatest problem in coverage is inconsistency, both from time to time, and claim examiner to claim examiner within the same intermediary, and from intermediary to intermediary. The most logical method of evaluating whether the intermediary is carrying out the intent of the regulations is periodic testing.
Consistency of audits.	Same as above.	Same as above.
Claims appeals.	Claims appeal rate would be determined by dividing the number of appeals by the total number of claims received for a designated time period.	At present, some intermediaries request more medical information prior to making a denial, thus lower cost to provider and intermediary, and ultimately to the program. This rate would give some indication of either lack of ability of the intermediary or of the provider and would need further investigation.
Audit appeals.	Audit appeals rate would be determined by dividing the number of appeals by the total number of audits completed for a designated period of time.	Essentially the same as number 5.
Appeals reversals.	Appeal reversal rate would be determined by the total number of reversals divided by the total number of appeals.	This rate would provide a good index for the quality of determination methodology of the intermediary.

Opportunity cost of paper work required by intermediary.	On a statistically valid random sample of providers served by an intermediary, calculate the amount of effort and the cost of supplying the information required by the intermediary. Include the cost of resubmitting items submitted more than one time and lost by the intermediary.	Some intermediaries require that the provider send in the claim only, others require as much as a summary of everything done on each visit. The cost can vary from a few cents per claim to several dollars per claim. Many providers submit pages of supporting medical documentation on a monthly basis to the intermediary with the claim as requested. The intermediary separates the information on receipt for its various departments and then claims not to have received as much as 20% of the information. Opportunity cost is the loss of revenue or service by the provider as a result of spending the time duplicating unnecessary paper work. Thus, the opportunity cost figure is considerably higher (usually 50%) than is the direct cost, as overhead is still attributed to the salary of the individual completing the paper work.
Claim processing. Cost per claim and per visit.	Calculate the cost required to process a claim and the cost per visit broken down into categories similar to the Home Health Cost Reporting Form.	Claim or audit costs are misleading. Visit cost would be a meaningful figure.
Audit cost per audit and per visit.	Calculate the audit cost per audit and per visit broken down by categories similar to the Home Health Cost Report Form.	Same as above.
Intermediary staff turnover rate.	Intermediary staff turnover rate can be calculated by any of the acceptable methods.	Intermediary staff turnover results in extra time that provider must spend with intermediary.

Provider satisfaction.	A questionnaire can be developed to determine provider satisfaction.	Discretion would be necessary to separate providers who are dissatisfied due to accurate denials.
Down time. Computer. Closed facility. Staff absenteeism.	Measure hours of time that facility was not operating by: a) number of hours his computer down divided by total hours of expected operation; b) number of days facility closed; c) unexpected staff absenteeism.	Down time by an intermediary may result in delayed payment to providers, thus causing provider to have to borrow money (at high interest rate) to pay payroll.

Chairman JACOBS. Mr. Levy.

STATEMENT OF MORRIS B. LEVY, EXECUTIVE DIRECTOR, AMERICAN FEDERATION OF HOME HEALTH AGENCIES

Mr. LEVY. Mr. Chairman, Mr. Rangel, I am Morrie Levy. I am the executive director of the American Federation of Home Health Agencies. The American Federation represents a greater percentage of the private sector than any other national organization representing the home health industry.

I have been executive director only since January 1982. But, I have had long experience in observing and interacting with the home health industry, administering the medicare and medicaid programs for the Federal Government. I was a member of the special medicare task force established in 1964 to plan the administration of the medicare care program. I have held a number of executive level positions in HCFA and its predecessor agency, the Bureau of Health Insurance. Most recently I was the Acting Deputy Director for Program Policy.

I mention this by way of background to indicate that the testimony I am about to offer not only reflects the views of the American Federation but also the experience I have acquired in administering the medicare and medicaid programs.

The American Federation would like to direct its comments and observations to three specific provisions of the fiscal 1983 budget: First, the proposal for a single medicare reimbursement limit for provider based and freestanding home health agencies; second, the introduction of coinsurance in home health services; third, the eliminiation of the waiver of liability protection for providers of services.

The American Federation of Home Health Agencies fully endorses the 1983 budget provisions to establish a single set of cost limits for provider based and freestanding home health agencies. Currently, the Health Care Financing Administration has by regulation established two sets of cost limits—one for provider based agencies, which are home health agencies operated as part of a hospital or nursing home, and one for freestanding agencies.

This two-tiered set of cost limits is objectionable for two reasons. First, it adds to medicare home health costs since it results in home health agencies operated as part of hospitals or nursing homes being reimbursed for up to 37 percent more than freestanding agencies for the same service.

The administration has estimated $18 million of savings in fiscal 1983 if a single set of limits were established. This is right along with estimates that the American Federation has developed and has submitted to this committee last year.

Second, it encourages the proliferation of provider based home health agencies irrespective of whether a locality is adequately served by existing agencies, further driving up costs.

These limits were first established by the Health Care Financing Administration in regulation in 1979. At that time HCFA established only a single set of limits because it specifically declined to set higher limits for provider based agencies, because according to HCFA, they did not want to pay for hospitals' inefficiencies.

But in regulations issued July 1, 1980, Mr. Chairman, HCFA established two sets of limits for the first time. The American Federation believes these two-level limits discriminate against small freestanding home health agencies who must compete against provider based agencies for the same services provided by freestanding agencies. If anything, provider agencies should be able to provide services of lower, not higher, cost than the small home health agencies because they can avail themselves of the economies of scale.

Since a two-level set of limits is contained in the regulations, HCFA could by moving promptly to revise its regulations, reinstitute a single set of limits and begin a start on achieving the $18 million savings projected for fiscal 1983. However, we believe the real way of doing this is to establish one set of limits through a legislative change.

The American Federation almost must object to two other provisions of the fiscal 1983 budget that affects home health agencies, and we recommend their deletion from the budget. First is a 5 percent co-payment for home health visits which represents a harsh, continuing erosion of a rapidly diminishing medicare benefit. It creates a barrier to patients obtaining home health services.

On the contrary, the administration, instead of erecting barriers, should be developing incentives to encourage patients to seek home health care which can be provided at a lower cost than care in institutions while permitting patients to live with dignity in their homes.

This provision is set forth to curb overutilization. We believe the proper way to correct overutilization is for HCFA to develop utilization criteria and issue them to providers and to intermediaries. As a matter of fact, Congress recommended this in the 1981 Omnibus Reconciliation Act in section 2152.

The waiver of liability authority has been in the medicare law since 1972. It has been a much needed part of medicare. It has worked well. If removed, home health agencies would face the risk of retroactive denial as claims for services rendered in good faith. It could lead to delays in providing physician-prescribed home health services to certain patients in certain cases where a fine judgment must be made by the provider and the intermediary about whether the services are covered.

We would turn back the clock 10 years when numerous small providers, including home health agencies, had to cease operating because of the uncertainties of being reimbursed for services rendered.

Mr. Chairman, we thank you very much for the opportunity of offering testimony this morning.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES

My name is Morris Levy, and I am the executive director of the American Federation of Home Health Agencies (AFHHA). I am very pleased to be able to present testimony to the House Ways and Means Committee on those provisions of the President's fiscal year 1983 budget that pertain to home health agencies.

AFHHA is a national trade association representing private, nonprofit and proprietary home health agencies across the United States. It was formed in September 1980 to present a carefully reasoned picture of the private sector of the home health industry to the Congress and the Health Care Financing Administration. AFHHA believes that constructive imput on behalf of the private sector of the industry had been noticeably lacking in the past. AFHHA represents a greater percentage of the private sector then any other national organization representing the home health industry.

While I have been the executive director of AFHHA only since January 1982, I personally have had long experience observing and interacting with the home health industry in administering the medicare and medicaid programs for the Federal Government. I was a member of a special Medicare Task Force established by the Social Security Administration in 1964 to plan the administration of the medicare program, and beginning with the enactment of title XVIII of the Social Security Act in 1965, have held a number of executive level positions in the Health Care Financing Administration and its predecessor agency, the Bureau of Health Insurance. At the time I left HCFA to assume my present responsibilites, I was the acting deputy director for program policy.

I mention this, by way of background, so that members of this committee will understand that this testimony represents not only the position of AFHHA but also reflects my direct experience in administering the medicare program for 16 years, including all aspects of medicare related to home health care. There are three specific provisions of the fiscal 1983 budget about which AFHHA would like to direct its comments and observations. These are: First, the proposal to set a single medicare reimbursement limit for hospital-based and free-standing home health agencies; second, the introduction of coinsurance in home health services; and third, the elimination of the waiver of liability provision for providers.

ESTABLISHMENT OF SINGLE REIMBURSEMENT LIMIT FOR PROVIDER-BASED AND FREE-STANDING HOME HEALTH AGENCIES

AFHHA fully endorses the proposal contained in the fiscal 1983 budget that establishes a single set of limits for free-standing and provider-based home health agencies. The concept of two sets of cost limits—one for provider-based home health agencies and another for free-standing home health agencies—was first established in regulation by the HCFA for cost-reporting periods beginning on or after July 1, 1980, and has been in effect ever since.

The two-tiered cost system established by HCFA has produced two lamentable results. First, it has added significantly to medicare costs of providing home health services since the system results in provider-based home health agencies being able to be reimbursed for up to 37 percent more than free-standing agencies for the same service. Second, it encourages the proliferation of provider-based home health agencies irrespective of whether a locality is adequately served by existing agencies.

This is because the provider-based agencies, which like free-standing agencies, primarily serve medicare patients, are able to absorb higher operating costs than existing free-standing agencies in an area due to the higher cost caps allowed. Since medicare patients constitute the bulk of the hospital's home health patients but on average only about 40–45 percent of a hospital's in-patients, hospitals receive a significantly higher proportion of the costs of operating a home health agency from medicare than they do for providing in-patient services. For example, a hospital running 40 percent medicare occupance is reimbursed for about 40 percent of its costs for providing in-patient service. A hospital-based home health agency with 90 percent medicare patients receives about 90 precent of the costs allocated to hospital-based home health agencies. And the hospital gets 90 percent of its costs at a higher level then a free-standing agency because of the two-level cost caps. Nationwide, home health agencies have a much higher proportion of their patients on medicare than the proportion of hospital patients that are on medicare. I would submit this is a powerful incentive to enter the market even in locations where the market already contains adequate number of freestanding home health agencies. The proliferation of agencies spreads out available patients over a larger number of agencies, which drives up the unit costs of delivering services for all agencies. The OMB estimates that eliminating the two sets of cost limits would produce fiscal 1983 savings of $18 million. This is in line with estimates the AFHHA prepared separately and furnished last year to this committee.

I would like to furnish you briefly with some additional background information about this costly and discriminatory provision. There are several types of home health agencies participating in medicare. In one group are the free-standing agencies. Another group are the so-called provider-based agencies. These are established by and operated as a part of a hospital usually, but sometimes as part of a skilled nursing home. In July 1979, under the authority provided by section 1861(v)(1) of the

Social Security Act, HCFA established by regulation, a set of limits for all home health agencies for the various services provided by those agencies. Medicare reimbursement, with certain exceptions, could not exceed the aggregate cost produced by applying the appropriate established limits for various home health services such as skilled nurses and physical therapists to the total visits of that service. When the limits were first established by HCFA, they applied equally to all types of home health agencies—free-standing and provider-based. In 1979, HCFA specifically declined to set higher limits for provider-based agencies because they did not want to pay for a hospitals' inefficiencies. However, they changed this policy when the initial update of the limits was issued effective July 1, 1980. For the first time HCFA established two sets of limits by regulation, one for free-standing home health agencies and a second set for provider-based agencies. The most recent set of limits established, for periods ending after September 1981, results in the provider-based limits being reimbursed as much as 37 percent more than the limits for free-standing home health agencies. AFHHA believes this two-level reimbursement approach discriminates against small free-standing home health agencies who compete against provider-based agencies that are in position to incur higher costs for the same services provided by the free-standing agencies. If anything, provider based agencies, most of whom are operated by hospitals, many of which are quite large, should be able to provide services at lower, not higher, costs than small home health agencies because they can avail themselves of the economies of scale. Notwithstanding this possibility, the free-standing agencies only ask that they be afforded an opportunity to compete on an equal basis with provider-based agencies, under a single set of cost limits applied equally to all home health agencies. We say, let's foster competition by allowing all the participants to compete equally. We are confident that in this environment the free-standing home health agency can provide high quality services. I would also observe that the two-level set of limits is contained in regulations and HCFA could, by moving promptly to revise its regulations to reinstitute a single set of limits, begin achieving the $18 million in savings projected for fiscal year 1983.

While AFHHA strongly supports the provision of the fiscal 1983 budget to establish a single set of cost limits, we must point out that the establishment of a single set of cost limits will only result in a limited improvement in the medicare reimbursement mechanism. Medicare's cost reimbursement system provides no incentives for lowering medical care costs. It is based on payment to providers for costs incurred, and thus the only incentive providers have is to make certain the services they provide are within the parameters of the established cost limits. AFHHA strongly believes that HCFA should move promptly to develop a prospective reimbursement system for all providers including home health agencies. AFHHA has stated its support of prospective reimbursement on numerious occasions in testimony before other congressional committees, and has offered to participate with HCFA in the development of a prospective reimbursement system for home health agencies.

COINSURANCE AND WAIVER OF LIABILITY PROVISIONS WOULD LIMIT ACCESS OF BENEFICIARIES TO SERVICES

The other two provisions of the fiscal 1983 budget that we wish to offer testimony on—a 5 percent copayment for home health visits and the revocation of the present waiver of liability provisions—will hurt medicare beneficiaries by limiting their access to lower cost home health services, and the AFHHA must oppose those provisions for this reason.

The coinsurance provision would add one additional financial burden to medicare beneficiaries who are experiencing severe financial hardships because of cutbacks in medicare already enacted and the deterioration of the economy. By the time the typical medicare beneficiary receives home health services, he or she has been hospitalized, incurred significant physician bills, requires medication, and often has also been an in-patient of a nursing home. Thus, the typical patient has had to meet the medicare in-patient hospital deductible of $260, a medicare part B deductible of $75, has had to pay 20 percent of all physicians' bills, pay for drugs and other medical supplies and if in a nursing home for more than 20 days, pay a daily charge of $32.50 beginning with the 21st day. For the elderly in our society, who are also facing cut-backs in food stamps and other forms of assistance and the withering away of their incomes due to inflation, this provision constitutes a harsh continuing erosion of rapidly diminishing health benefit. It is particularly misplaced since it creates a barrier to patients obtaining home health services. These services can be provided at lower cost while permitting patients the choice of living with dignity in their homes instead of impersonal institutions. AFHHA urges that incentives be created to encourage less costly, more dignified care, rather than roadblocks which either encourage patients to remain in more costly settings or defer obtaining needed services.

Under the medicare hospital provisions, once the $260 hospital deductible is met, a patient does not incur copayment for hospital days until the 61st day. Since the average hospital stay for a medicare patient is around 11 days, there would be an obvious incentive, if this provision were enacted, for a patient to stay several more days to avoid or minimize having to use home health benefits that would require payment of coinsurance. While a 5 percent copayment per visit seems small, standing by itself, for those with little income it can be extremely formidable.

Moreover, the material the AFHHA has seen on the estimated savings from the provision does not indicate whether calculations have been made to determine how much more costly hospital or nursing home expenditures medicare would incur because of the incentive it would produce to stay longer in institutions where no copayment is required. Parenthetically, I would remind the members of this committee of the recent testimony of the American Health Care Association, before the Subcommittee on Health of this Committee, that at any given day there are 19,000 medicare beneficiaries backed up in hospitals wasting medicare dollars on high-cost hospital care awaiting a SNF bed. While many of those patients undoubtedly require SNF care, studies have shown that 25 percent of the patients in SNF's could be sent home if adequate home care services were made available. We believe this provision will exacerbate the problem the AHCA brought to the attention of this subcommittee. The administration proposes this provision as a deterrent to unnecessary utilization of services, but it has offered no evidence that cost sharing would, in fact, discourage utilization of services. While AFFHA fully endorses actions to curb over-utilization of services, we do not believe the concept of coinsurance, which would discourage patients from obtaining needed services, is the way to deal with this issue. The best way to assure that medicare pays for needed home covered home health services is for HCFA to develop utilization guidelines that would be made available to home health agencies and intermediaries. This would implement a provision of the Omnibus Reconciliation Act of 1981, Section 2152. AFHHA would be pleased to work with HCFA in developing these guidelines.

Finally, AFHHA must object strongly to the provision which eliminates the safeguards to providers under section 1879, the limitation of liability for disallowed claims section of the medicare law. Section 1879 was enacted as part of the 1972 amendments to the Social Security Act. I can tell you from first-hand knowledge that prior to its enactment providers of services—hospitals, nursing homes, and home health agencies—were faced with a real crisis that led numerous small providers, particularly small home health agencies, to close down their operations. This was because, absent this provision, providers could, in good faith, incur expenses to provide services only to have medicare retrospectively deny the bills for the services furnished. A provider's only recourse was to attempt to collect from the patient but, because of the economic circumstances facing most of the elderly, this was a most unsatisfactory situation. Obviously, neither home health agencies nor other entrepreneurs could for long, pay salaries and purchase supplies to provide services for which they would not be paid.

Responding to this dilemma, Congress enacted the limitation of liability provision, or as it is more often referred to, the waiver of liability provision. In essence, it provides that when services furnished were determined by the fiscal intermediary to be not covered, but neither the patient or the provider knew or reasonably could have been expected to know the services were not covered, the Government would accept liability and reimburse the provider. This eminently fair and reasonably provision solved the retroactive denial problem in practically all cases and enabled providers to furnish services with confidence of obtaining reimbursement. Now, the administration wants to delete this provison and, in its place, create even a harsher situation than existed back in 1972. Before the enactment of section 1879, providers experiencing retroactive denials for noncovered services could attempt to collect from the patient. Under the proposed provision, the provider would be completely and totally liable.

AFHHA believes there are misunderstandings about governments financial exposure under the waiver of liability provision. A waiver does not result in medicare for extensive amounts of noncovered services. The present provision includes very close controls and limitations. To qualify for the protection afforded, a provider must demonstrate a thorough understanding of the medicare coverage criteria. It can demonstrate such understanding if, in the case of a home health agency, its denial rate does not exceed 2½ percent of all visits billed. Moreover, intermediaries reevaluate each provider at least every 3 months or even more frequently if they wish. Whenever an agency's denial experience exceeds 2½ percent for a quarter, it no longer qualifies for waiver of liability status. It can qualify again only after it is able to demonstrate knowledge of the coverage criteria by having a 2½ percent denial rate or less. Even where the provider has limited liability status it must still demonstrate it did not know or could have been expected to know that the services it furnished were not covered. Where the provider demonstrates lack of knowledge they cannot be reimbursed for subsequent billings for the same services since once payment is made under this provision the provider has notice that the services are not covered. If this provision is removed, home health agencies and other providers of services could not be sure of receiving reimbursement for a number of cases that require a fine judgment by the provider and intermediary on whether the medicare level of care requirements are met. Providers now can begin to furnish services on these cases, under waiver of liability, immediately upon receipt of a physician order. But, not knowing if reimbursement would be made, providers may have to delay offering these services to the patients disadvantage until the intermediary could furnish them with a coverage decision. Currently, different intermediaries frequently reach differing decisions on these cases depending on all the factors present. Many refuse to render a judgment at all before a claim is filed. There are no general criteria home health agencies can follow.

For example, a patient with arteriosclerotic heart diseases, whose vital signs, degree of edema, and extent of cardiac involvment has to be evaluated individually and in relationship with one another to judge whether or not the patients medical condition is sufficiently unstable to require skilled nursing care, which medicare can pay for under the home health provisions. Another example would be a diabetic patient on insulin, hospitalized because of an adverse insulin reaction. When this patient is discharged to the home, his or her diet, insulin dosage, and ability to follow a diet must be closely monitored. The patient is weak and has some real functional limitations. In these cases, the home health agency and the intermediary face a tough decision as to whether the patient retains sufficient functional mobility so that he or she could not be considered home-bound, the basic requirement to receive home health care benefits. It is not possible to make a blanket decision from the diagnosis in this type of case. The home health agency needs some assurance so it can begin offering services while difficult coverage decisions are being made. We will furnish, for the committees' consideration, examples of actual cases such as the ones described above.

Mr. Chairman and members of this committee, the waiver of liability provision has been a much needed addition to the medicare law. It has, since 1972, worked well. If removed, as proposed, it will put providers at much greater risk, lead them to limit the services they can offer to many beneficiaries, and turn the clock back 10 years when providers were faced with sizeable amounts of nonrecoverable funds for services rendered in good faith. AFHHA most strongly recommends that this provision be eliminated from the 1983 fiscal budget.

Mr. Chairman this concludes our testimony. On behalf of AFHHA, we appreciate this opportunity of making our views known.

Chairman JACOBS. Thank you, Mr. Levy; 5 minutes, 38 seconds. Mr. Rangel.

Mr. RANGEL. No questions, Mr. Chairman.

Chairman JACOBS. I have one question for Ms. Suther.

Mr. Levy's organization has taken a strong position in support of the elimination of the dual caps. Does your organization have a position on that?

Ms. SUTHER. Our organization is a newly merged organization, and our board has not taken a position on that.

Chairman JACOBS. Have you an opinion yourself?

Ms. SUTHER. I have a personal opinion. My personal opinion is that it is a misunderstood issue and that people do not always look at the method of overhead allocation for hospitals, and if the method of overhead allocation for hospital home-based agencies were changed, that might affect the opinion that people would have relative to dual cost limits.

Chairman JACOBS. Thank you very much for your contribution to the record.

The next witness, representing the PSRO's, Dr. Harry Weeks.

STATEMENT OF HARRY S. WEEKS, JR., M.D., PAST PRESIDENT, AMERICAN ASSOCIATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS, ACCOMPANIED BY LYLA HERNANDEZ, EXECUTIVE DIRECTOR

Dr. WEEKS. Mr. Chairman, thank you. My name is Harry Weeks, and I am a practicing physician from Wheeling, W. Va., and past president of the American Association of PSRO's. With me today is Mrs. Lyla Hernandez, executive director of AAPSRO.

We thank you for providing us this opportunity to comment on the administration's proposals for medicare and the PSRO program. I will attempt to paraphrase our summary statement to meet your time constraints.

It is the position of our association that the administration's proposal that the repeal of the PSRO law would result in savings to the Federal Government is based on erroneous calculations for the following reasons.

The administration's figures representing savings take into account only the administrative cost of PSRO and completely ignores savings achieved through the PSRO review. Data published by the Health Care Financing Administration show those 70 PSRO's in operation today and fully implemented during 1978 and 1979 achieved a reduction in medicare patient days of approximately 647,000 days. In 1979 the American Hospital Association estimated that it would cost $217 per patient day to provide services.

In evaluating PSRO savings in the past, HCFA used 40 percent of the cost per day to calculate savings. We have used an even more conservative figure of 33 percent. The reduction in days achieved by those 70 PSRO's then amounts to an estimated savings of over $46 million.

In addition to this, our own analysis of PSRO achievements based on 1979 and 1980 reports show that 71 PSRO's having information such that they could report on medicare savings shows a reduction of 710,000 days with an estimated savings of $57 million.

As you are aware, PSRO's also address quality of care issues and other issues involved in the health care system. Recently a PSRO in North Carolina was able to reduce one hospital's mortality rate due to heart attack by 37 percent. We cannot put a dollar figure on this accomplishment, but I am sure the patients whose lives were saved view this as invaluable.

The PSRO in Milwaukee, Wis., was able to reduce repeat X-rays by 30 percent. This amounted to a reduction over 1 year of more than 80,000 unnecessary X-rays and resulted in savings greater than the entire budget of that particular PSRO. Other PSRO's are even now doing the same thing in their own areas.

Evaluations conducted by HCFA and the Congressional Budget Office conclude that PSRO's saved more for medicare than they cost the Government to operate.

Last year the Congress mandated that only those PSRO's which are effective should remain. That mandate has led to the elimination of the ineffective organizations. Those remaining, from the No. 1 ranked PSRO in South Carolina through the other 147 in operation today, are organizations which passed the test of effectiveness. Eliminating PSRO, therefore, appears to go totally against what this Congress and this administration are attempting to do. Eliminating this program will only increase the cost of medicare, not reduce those costs.

Thank you very much, sir.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN ASSOCIATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SUMMARY

The American Association of Professional Standards Review Organizations opposes the administration recommendation to repeal the PSRO program.

The administration alleges that repeal of PSRO will save money.

This allegation is erroneous and ignores savings achieved through PSRO review.

HCFA data show 70 PSRO's achieved reductions in medicare average length of stay between 1978 and 1979 totalling 647,634 days.

This reduction amounts to an estimated savings of $46,448,310.

Our own analysis shows that in 1980, seventy-one PSRO's achieved reductions of 7100,113 days for an estimated savings of $57,441,041.

PSROs also do other things such as reducing the mortality rate due to heart attacks and eliminating unnecessary repeat X-rays.

Evaluations conducted by HCFA and the Congressional Budget Office show PSRO's save more for the medicare program than they cost the Federal Government.

Eliminating the PSRO program flies in the face of what this administration is attempting to accomplish, that is, to reduce the escalating costs of health care services paid for through the medicare program.

STATEMENT

Mr. Chairman, my name is Harry S. Weeks, Jr., and I am a practicing physician from Wheeling, W. Va., and past president of the American Association of Professional Standards Review Organizations.

With me today is Lyla Hernandez, executive director of the American Association of PSRO's.

We thank you for providing us the opportunity to comment on the administration's proposals for medicare and the PSRO program.

As you are aware, the administration is proposing that both the utilization review requirements and the PSRO law be repealed.

By repealing these programs, the administration claims dollar savings. Not unexpectedly, however, these figures do not accurately reflect the true picture. The administration's budget proposal for fiscal year 1983 credits savings for the administrative costs of operating the PSRO program but ignores the loss of savings to the Federal Government achieved through PSRO activities—savings which even the Government's own evaluations indicate are in excess of the costs of operating the program.

We think it is important to look at what the PSRO program is accomplishing. To do so, we have arrayed for you data on PSRO impact on reducing medicare average length of stay (ALOS). These data are from a report compiled and published by the Health Care Financing Administration and cover the two most recent years for which such data are available, 1978 and 1979.

The best measure for utilization effectiveness is, of course, days of care per thousand beneficiary (DOC/1000). That measure is a more accurate reflection of impact because it takes into account both the average length of stay and the admission rate and shows actual days of care used.

In some areas of the country, for example, average length of stay is very low but this low figure may be partly attributable to high admission rates.

PSRO's with high admission rates and low lengths of stay (such as those in California) would concentrate their efforts on reducing the admission rate. By reducing the admission rate, the average length of stay would most likely increase slightly, but the total days of care per thousand—days actually spent in the hospital—would decrease.

Unfortunately, HCFA was not able to furnish us with data on days of care per thousand. But absent these data, we are confident there is a high correlation between reductions in average length of stay and reductions in days of care per thousand.

The PSRO's included in the table on medicare average length of stay are those PSRO's which are in operation today and which were fully implemented for the years 1978 and 1979. As you can see, of the 70 PSRO's for which data are available, 51 show decreases in the medicare average length of stay amounting to total days saved of 711,828 days. Eleven of the 70 PSRO's showed an increase in medicare ALOS amounting to a total increase of 64,194 days while the remaining eight PSRO's showed no change in medicare ALOS.

The total reduction in days achieved by these PSRO's, then, is 647,634 days. The American Hospital Association estimated the cost of providing services per patient day in 1979 was $217.34. Rather than using 40 percent of this cost to estimate savings as HCFA does when it evaluates PSRO, we used 33 percent. The reduction in days achieved by these PSRO's, then, amounts to an estimated savings of $46,448,310. The administration's budget proposals do not indicate that this money now being saved by PSRO's through such reductions would be lost and that increased medicare costs will result if PSRO's were eliminated.

As you hold your hearings, we are just finishing our own analysis which is based on data obtained directly from PSRO statistical reports for the years 1979 and 1980. This report includes information on PSRO achievements in the areas of both utilization reduction and quality improvement. We will send copies to the committee as soon as the report is completed.

In order to estimate the dollar savings achieved through PSRO reductions in unnecessary hospitalization, we took one-third of the American Hospital Association's figure for the cost per inpatient day in 1980 ($245.12) as the figure to compute total savings. The Health Care Financing Administration uses 40 percent of this figure rather than the more conservative figure of 33 percent.

Here are the results on PSRO impact during 1980 alone.

Eleven PSRO's had information such that they could report on days of care per thousand medicare beneficiaries. These PRSO's reported reductions in days of care per thousand medicare beneficiaries amounting to a total reduction of 93,058 days or a savings of $7,527,462.

Another twenty PRSO's reported decreases in medicare average length of stay totaling 570,791 days for an additional savings of $46,171,284.

An additional twenty PSRO's reported they had achieved reductions in lengths of stay for various procedures amounting to another 18,075 days or $1,462,087 saved.

Twenty other PSRO's reported achieving reductions in diagnosis-specific lengths of stay totaling 28,189 days for a savings of $2,280,208.

And, of course, PSRO's do not concentrate solely on reducing lengths of stay or days of care per thousand. They also identify and correct problems in the quality of patient care. For example, the Central Piedmont PSRO located in Durham, N.C., found that one hospital in its area had a mortality rate for acute myocardial infraction of 47 percent—a rate judged much too high by the physicians in that PSRO.

PSRO physicians met with physicians in that hospital, discussed how AMI patients should be treated and pointed out problem areas. The PSRO then conducted on-site monitoring of patients admitted to that hospital with AMI to insure that appropriate changes were being implemented. The result—a 37 percent reduction in the mortality rate.

How does one calculate in dollars what that single reduction is worth?

PSROs also identify and elminate unnecessary use of ancillary services. The PSRO located in Milwaukee, Wis., for example, identified that 6.5 percent of the X-rays in its area were retakes (the average retake rate for the U.S. is 9 percent–10 percent) This PSRO investigated and determined the causes of these repeat X-rays, implemented corrective action designed to eliminate the causes and achieved over a 30 percent reduction in the retake rate. This 30 percent reduction translates into elimination of over 85,000 unnecessary X-rays over a year's time.

At $15 per X-ray, this reduction translates into a costs savings of over $1,275,000—substantially more than the entire budget of that one PSRO for a full year. In addition, radiation exposure from the unnecessary X-rays has been reduced.

Mr. Chairman, these are just some of the examples of what PSRO's have been able to accomplish. It is not only our data that show PSRO's save more for medicare than they cost the Federal Government to operate. These same conclusions were reached by the Health Care Financing Administration and by the Congressional Budget Office.

Eliminating PSRO, then, appears to us to go totally against what this Congress and this administration are attempting to accomplish, that is, to reduce the escalating costs of health care services paid for through the medicare program.

Thank you, Mr. Chairman. I will be happy to answer any questions you may have.

REDUCTIONS IN MEDICARE L.O.S. BY PSRO

PSRO	Average length of stay		Total reduction in days
	1978	1979	
Vermont	9.4	9.4	No change.
New Hampshire FMC	8.9	8.8	3,278
New York:			
PSRO of Central New York	10.2	9.8	18,583
Five County	10.3	9.8	7,713
Adirondack	11.2	10.6	11,879
Area 9 of New York State	11.9	11.3	16,275
Rockland	11.3	10.5	5,501
New York Country Health Services Review Organization	12.5	11.8	59,583
Queens County	13.2	12.4	36,472
Nassau Physicians Review	11.9	11.4	18,438
The Bronx	13.0	12.0	33,325
Massachusetts:			
Western Massachusetts	10.4	10.2	6,797
Central Massachusetts	10.7	10.2	11,942
Eastern Massachusetts	11.5	11.3	23,550
Southeastern Massachusetts	10.7	10.4	9,786
Rhode Island	11.1	10.9	7,520
Connecticut:			
Connecticut Area II	10.9	10.6	8,116
Hartford County	10.3	10.6	8,473
New Jersey			
Area I, Region II	11.6	11.4	3,085
Passaic Valley	11.9	11.5	6,692
Essex Physicians Review Organization	11.9	11.8	3,775
Southern New Jersey	12.1	11.9	9,126
Pennsylvania:			
Eastern Pennsylvania Health Care Foundation	11.4	11.0	8,603
Southwestern Pennsylvania	10.3	10.5	7,757
Highlands Corporation	10.5	10.2	6,766
Southcentral Pennsylvania	11.1	10.8	18,196
Delaware Review Organization	11.2	10.6	9,118
Maryland:			
Baltimore City	12.7	12.6	3,587
Prince Georges FMC	10.8	10.8	No Change.
Delmarva FMC	10.3	10.2	1,081
National Capital Medical Care Foundation	11.2	11.0	5,072
West Virginia Medical Institute	9.3	9.0	29,181
Virginia: Colonial Virginia FMC	10.8	11.0	6,780
South Carolina Medical Care Foundation	9.1	9.0	7,586
Kentucky Peer Review Organization	8.8	8.7	15,975
Alabama Medical Review	9.0	8.8	35,542
Mississippi FMC	8.8	8.6	24,542
Wisconsin:			
Wisconsin Professional Review Organization	9.1	9.0	11,957
FMC of Southeastern Wisconsin	11.1	11.1	No change.
Michigan: Upper Peninsula Quality Assurance Association	9.1	9.8	7,869
Ohio:			
Region II Medical Review	10.9	10.8	3,293
Fourth Ohio Area Council	10.2	10.0	6,849
Region X Peer Review Systems	11.3	10.9	9,173
Physicians Peer Review Organization	11.9	11.5	26,781

REDUCTIONS IN MEDICARE L.O.S. BY PSRO—Continued

PSRO	Average length of stay		Total reduction in days
	1978	1979	
Illinois: Chicago FMC	12.2	12.2	No change.
Minnesota: Foundation for Health Care Evaluation	9.9	9.3	72,652
North Dakota Health Care Review	8.5	8.3	7,725
South Dakota FMC	8.3	8.2	3,594
Iowa FMC	9.1	8.8	36,129
Missouri:			
Mid-Missouri Foundation	9.7	9.5	7,279
MOAF	9.2	9.3	3,486
Southeast Missouri	9.0	8.8	4,915
Arkansas FMC	8.1	8.0	12,833
Montana FMC	7.1	7.1	No change.
Colorado FMC	8.8	8.7	9,129
Utah	7.5	7.4	3,456
New Mexico	7.3	7.4	3,704
Nevada	8.1	8.1	No change.
Washington State	7.4	7.3	13,719
Oregon:			
Multnomah FMC	8.6	8.6	No change.
Greater Oregon	7.2	7.3	5,854
California:			
Redwood Coast Region	7.0	7.2	2,134
North Bay	8.3	8.4	1,891
Greater Sacramento	7.4	7.5	3,416
San Francisco	9.6	9.6	No change.
San Joaquin Area	7.4	7.2	3,105
Santa Clara Valley	8.2	7.9	7,338
Kern County	7.1	7.0	1,401
Area XXIV	9.2	9.1	3,895
Riverside County	7.1	7.6	12,830

Chairman JACOBS. Thank you.

You have won the dollar so far. I thought you would be glad to hear that.

Dr. WEEKS. Thank you, sir.

Chairman JACOBS. Mr. Rangel.

Mr. RANGEL. No questions, Mr. Chairman.

Chairman JACOBS. Generally speaking, your testimony comes down to this: Unless there is some other way for the Government to trace where its money is going, unless competition or something comes into play, it might be premature to do away with this method, is that correct?

Dr. WEEKS. Absolutely. We do not know what we are looking at in the future, and I think it is just sort of silly to kick what you have going for you in lieu of something more questionable.

Chairman JACOBS. We thank you for your testimony, Doctor.

The next panel is, generally speaking, associations of Government employees. Will you please come forward?

The beauty of this is that each of you gentlemen knows exactly who he is, so in the interest of time will you identify yourselves as you testify.

STATEMENT OF VINCENT R. SOMBROTTO, PRESIDENT, NATIONAL ASSOCIATION OF LETTER CARRIERS, ON BEHALF OF THE FUND FOR ASSURING AN INDEPENDENT RETIREMENT

Mr. SOMBROTTO. I thought the beauty of it was us.

I will go on record as saying I am going to win the dollar.

Chairman JACOBS. You should say out of modesty——

Mr. SOMBROTTO. My name is Vincent R. Sombrotto, president, National Association of Letter Carriers. My statement today represents the views of my union and is consistent with the position of the 25 postal and Federal groups belonging to FAIR, the Fund for Assuring an Independent Retirement. I will submit for the record a statement on behalf of FAIR.

Mr. Chairman, I go on record today to oppose President Reagan's proposal to place a 1.3 percent medicare tax on postal and Federal employees. Singling out Federal workers and taxing them for a benefit they neither want nor need is discriminatory and unnecessary. Letter carriers currently have adequate health care coverage through the NALC health benefit plan, which can be carried into retirement, with retirees continuing to pay their share of the premiums.

Mr. Chairman, I take issue with President Reagan's claim that Federal workers are already receiving this benefit without paying for it. Anyone who receives medicare can only do so by contributing the minimum quarters necessary to qualify, receive it as the spouse of a covered worker who has paid the tax, or purchase it at age 65 at the prevailing rate.

President Reagan views this proposal as a way of increasing revenues, while at the same he proposes to cut medicare benefits by $2.5 billion. Taxing us $619 million may be a short-term gain for the health insurance fund. However, over the long run the added participants will be affected by the same projected increase in medical costs, adding to the total cost of the system.

In other words, Mr. Chairman, this is another example of a Reagan short-term budget savings that disregards long-term costs that you and other Members of Congress will have to face in the future.

Mr. Chairman, that completes my testimony. I will be happy to respond to any questions you may have. Thank you.

I will be looking forward to the dollar.

Chairman JACOBS. We thank you for the testimony. Let us see whether you are going to get it or not; 1 minute and 35 seconds. I was warned about the other witness. Please proceed; 1, 35.

STATEMENT OF MOE BILLER, GENERAL PRESIDENT, AMERICAN POSTAL WORKERS UNION, AFL–CIO

Mr. BILLER. Mr. Chairman, my name is Moe Biller. I will not meet that record. I am general president of the American Postal Workers Union, an affiliate of the AFL–CIO. I appreciate the opportunity to appear here today to discuss our position on the medicare tax on Federal and postal employees.

The Reagan administration, in its efforts to reorder the Federal budget, has singled out Federal and postal employees for unfair and injurious treatment. Health insurance benefits have been reduced, leaving employees with less than the average private sector employee benefit. Adequate compensation for on-the-job injury or work-related disease is threatened. There is little Federal job security and loss of income through unpaid furloughs is becoming all too common.

Proposed pay increases for the Federal employees do not begin to offset the effects of inflation. Cost of living increases for Federal and postal retirees have been reduced and further cuts are proposed.

On top of all these, the Reagan administration has proposed to collect from Federal and postal employees a new tax equal to 1.3 percent of salary. The new tax will raise revenues of $619 million in fiscal year 1983. This money taken from the pockets of beleaguered Federal and postal workers and their families will further the Reagan administration's policies of taking from the poor and middle income workers to give to the rich.

In return for enriching the Federal coffers by more than $600 million per year, Federal and postal workers will be eligible for medicare coverage, a benefit which is not needed because it duplicates health insurance coverage already available under the FEHBA program. Under the terms of FEHBA, which was enacted in 1959 and amended some 10 years later, Federal and postal employees may carry their health benefits coverage into retirement by continuing to pay their share of the premium. Thus for Federal employees a promise of medicare coverage is not worth the cost.

If the medicare tax is imposed and postal and Federal employees are brought under medicare, a major issue remains concerning postal and Federal annuitants who are not now eligible for medicare coverage. If FEHBA coverage is to become a supplement to medicare coverage for Federal and postal employees who retire, granting medicare eligibility for current annuitants may be called for if the new system is to be equitable. This issue must be explored in detail before consideration of extension of medicare to Federal and postal employees.

Mr. Chairman, the APWU is inalterably opposed to the administration's plan to unfairly tax postal and Federal workers. The continuing attacks on workers through arbitrary, capricious cuts in existing benefits, and imposition of increased payroll taxes must be stopped. Treating Federal and postal employees like second-class citizens will in the long run undermine the strength of the Government itself.

Mr. Chairman, I appreciate your time today and urge the committee to protect the hundreds of thousands of postal and Federal workers and their families in your districts by opposing this unfair tax. We cannot balance the budget on the backs of postal and Federal workers.

Chairman JACOBS. Pretty good, Mr. Biller; 3 minutes, 3 seconds. And actually, I liked the substance of what you had to say.

STATEMENT OF KENNETH DOYLE, DIRECTOR OF INSURANCE, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Mr. DOYLE. Mr. Chairman and members of the committee, I am Kenneth Doyle, director of insurance for the American Federation of Government Employees, AFL-CIO. I appreciate the opportunity to appear before the committee today and comment briefly on the President's proposal to extend the medicare tax to all Federal and postal employees.

Since you will receive the written comments of FAIR submitted on behalf of all of its affiliated organizations and not just the ones seated around the table this afternoon, I will not reiterate what is in that report, but merely add our full and unqualified endorsement of the FAIR position opposing the President's proposal.

In addition, I would like to examine briefly what if any value there would be in extending medicare coverage to Federal employees. The medicare program was enacted by Congress in 1965 in order to assist those individuals receiving social security cash benefits in meeting the cost of necessary health care.

The three basic principles which motivated its enactment were: First, that health care costs fluctuated greatly between individuals and could not be adequately budgeted for; second, that adequate and affordable health care insurance in the private sector was largely available only through group coverage; and that third, the premium costs for individuals were too high to be borne by individuals with minimal retirement income.

Upon examination, we believe that none of these criteria which justify the existence of medicare are applicable to the vast majority of Federal retirees. Because Federal employees who have been participants in the Federal employee health benefit program for the last 5 years preceding their retirement can continue to carry their group insurance coverage with them into retirement, there is little or no need for those persons to purchase the supplementary coverage offered through medicare.

Group insurance offered through the Federal employees health benefits program even at the most minimal levels far exceeds the coverage provided under medicare. For example, medicare benefits covering hospital care are now based on the concept known as a spell of illness which extends for 90 days.

In addition, each beneficiary has a lifetime reserve of 60 days of hospital care for spells of illness that began on or after January 1, 1981. The patient must pay the initial deductible of $204 for hospital care and the coinsurance of $51 per day with the 61st to the 90th day of hospitalization. Once the 60-day lifetime reserve is exhausted, the medicare recipient must pay $102 per day for any additional hospital or institutional care.

By contrast, the AFGE health benefit plan which employees may carry through retirement years pays 100 percent of the cost of hospitalization up to 365 days per spell of illness, with the exception of a $25 per day deductible for the first 10 days. Obviously, a Federal retiree would fare better under the AFGE health benefits plan than under medicare.

Although the National Commission on Social Security in its report entitled "Social Security and America's Future" recommends a number of significant improvements in medicare hospital benefits, including the elimination of the lifetime reserve concept and the extension of limitation on the number of days covered up to 150, there is no indication that these recommendations will receive favorable consideration by Congress or are even affordable under today's economic conditions.

In conclusion, Mr. Chairman, we see little value in the administration's medicare proposal beyond the fact that it would effect massive infusion of new funds into severely troubled medicare trust funds.

This concludes my statement and I would be pleased to answer any questions that the subcommittee may have.

Chairman JACOBS. Thank you, Mr. Doyle; 3 minutes, 39 seconds.

Mr. Gusky.

STATEMENT OF DAVID GUSKY, NATIONAL FEDERATION OF FEDERAL EMPLOYEES

Mr. GUSKY. Mr. Chairman, my name is David Gusky. We have a prepared statement which we will submit for the record and, rather than repeat the remarks of my colleagues at the table, I will simply state that they have explained our position very well and I will just associate myself with their remarks.

Thank you.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL FEDERATION OF FEDERAL EMPLOYEES

Mr. Chairman and subcommittee members, the National Federation of Federal Employees is pleased to appear today to discuss the Reagan administration's proposal to extend medicare coverage to the Federal work force. NFFE is adamantly opposed to this recommendation and we appreciate the opportunity to briefly state our objections.

First, we strongly disagree with the administration's implication that Federal employees who are entitled to medicare do not legally deserve these benefits. No Federal worker currently is covered by medicare unless he or she has met the requirements established by law. The administration implies that Federal employees are somehow "freeloading" off the system. This is completely untrue.

If the administration believes the criteria for medicare eligibility is too liberal, then it should suggest measures to tighten it for all individuals. It should not point to Federal workers as a singular group which abuses the system. Civil servants with medicare eligibility are receiving only what they have earned and are entitled to under present law.

Second, medicare coverage for Federal workers would exact a heavy financial toll. Employees in private industry, particularly those with large firms, usually enjoy health insurance plans paid for entirely by their employers. Federal workers, on the other hand, pay a high price for health insurance. The average annual premiums are $362.00 for self-only coverage and $775.00 for family coverage. The administration wishes to increase these charges by an average of $260.00 a year.

When you consider the widespread pay, benefit and job cuts experienced by the Federal work force during the previous year, and those planned for this year, it's unconscionable that a proposal of this nature should surface now. There seems to be no end to what the administration can devise to cut civil service compensation and further demoralize the Federal work force.

Finally, extending medicare coverage to Federal employees could be construed as the first step toward full social security coverage. As NFFE has explained many times in the past, this is a most onerous prospect for the social security system as well as Federal workers. It would also break the administration's promise to keep the civil service retirement program separate from social security.

In conclusion, NFFE hopes this subcommittee and the entire Congress rejects the proposal to extend medicare coverage to Federal workers. Viewed in the proper light, we believe the recommendation is simply another clumsy cost-cutting attempt by an administration whose efforts to reduce the Federal spending bear little relationship to sound program management.

That concludes my statement. I will be happy to answer any questions.

Chairman **Jacobs**. That is 1 minute, 19 seconds. You are the winner so far.

Mr. **Gusky**. I hope I can at least get a lunch out of this.

Chairman **Jacobs**. Mr. Klepner.

STATEMENT OF JERRY D. KLEPNER, DIRECTOR OF LEGISLATION, NATIONAL TREASURY EMPLOYEES UNION

Mr. **Klepner**. It is going to be tough, but I will see if I can meet Mr. Gusky.

My name is Jerry Klepner. I am director of legislation for the National Treasury Employees Union. I also would like to associate myself with the remarks of my colleagues, and I would like to emphasize just two points.

The administration projects that through the universal medicare proposal there would be an increase in revenue of $619 million to the medicare system. If each and every present Federal retiree was placed under that system, it would result in an increase of outlay of $880 million, which means that there would be over a $200 million shortfall as a result of this proposal.

In addition, projecting a 5-percent pay raise for the upcoming October general schedule and a 25-percent increase in the health insurance premiums, we have put together information which demonstrates that a GS-3 employee after the pay raise would have a net loss of $52 if that individual must pay the medicare tax, the GS-5 employee would have a net gain of only $22, a GS-7 would have a net loss of $19, a GS-9 a net gain of $56, and a GS-13 at the very top would have a net gain of only $145.

It seems to us in reviewing this proposal that it makes very little sense, both from the standpoint of the health insurance trust fund, which would have to pay more in outlays than it would receive in revenue, and it makes even less sense from the point of view of the employee, who is adequately covered now by the health benefits program and through this proposal would suffer a substantial loss in income in terms of a reduction in the October pay raise.

With that, I would thank you very much, and I would be happy to join with my colleagues in answering any questions.

[The following statement was subsequently received:]

Statement of Jerry D. Klepner, Director of Legislation, National Treasury Employees Union

I am Jerry D. Klepner, director of legislation of the National Treasury Employees Union. Our union is the exclusive representative of over 120,000 U.S. Government workers in numerous Federal agencies.

We appreciate this opportunity to present our views on the administration's fiscal year 1983 budget submission concerning Government health programs. We would like to specifically direct our remarks to that proposal which would mandate coverage of all Federal workers under the medicare system.

Let us indicate at the outset that our union is firmly opposed to the adoption of the so-called universal medicare scheme. In our view, the proposal violates the principles of sound economics and of equity.

We know that this subcommitee has the awesome responsibility of examining programs which have a great impact upon the health care of millions of Americans. We are fully aware that the medicare system is under a financial strain in these times of spiralling inflation and high unemployment. Nevertheless, we submit that scapegoating the Federal employee for the very real problems of our health care system is hardly a viable solution.

Under the administration's proposal, Federal employees would pay 1.3 percent of their earnings, to the current social security maximum of $32,400, to finance a universal medicare coverage plan. This program would entitle Government workers, with a required number of years of service, to qualify for medicare at age 65. Currently, only those individuals who are eligible for social security or who pay medicare premiums can receive benefits under this program.

To justify this change, the Office of Management and Budget (OMB) claims that in the next few years 80 percent of Federal workers over 65 will qualify for medicare coverage on the basis of spouse earnings or periods of employment in the private sector even though they did not pay the medicare tax for the majority of their careers. According to the administration, universal medicare coverage would improve the solvency of the Health Insurance Trust Fund, which finances the system, and would constitute more equitable treatment of Federal workers.

While these contentions appear reasonable at first blush they will not withstand further scrutiny. Federal employees have not been included under medicare for sound and well advised reasons. In 1959, Congress created the Federal Employees Health Benefit Program (FEHBP). This system provides comprehensive health care to both active and retired Government workers. Unlike most plans at the time, the FEHBP extended medical coverage to retired employees, protecting this group of individuals from the high costs of health care which must be borne by the elderly. Six years after the creation of the FEHBP, Congress enacted the medicare law. Since Federal employees did not need, or did they desire, coverage under the new health care system, Congress did not include them in the program.

The administration is now seeking to reverse this long standing policy on the grounds that the vast majority of Government retirees will receive medicare without having paid the payroll tax. The OMB, however, has not supported this claim with any evidence. We urge the subcommittee to keep in mind that those Federal retirees who receive medicare do so only according to the requirements of the law.

In 1965, when medicare was created, virtually all individuals who were age 65 and older gained coverage, including former Government workers. Because over 15 years have passed since that time, most of these individuals are no longer alive. Other Federal retirees who qualify for medicare coverage do so because they are also eligible for social security as a result of periods of work in the private sector. We must emphasize that these retirees only receive benefits pursuant to the strict guidelines of the medicare and social security laws. According to the statute, a worker must be employed in private business for a precise number of quarters in order to satisfy eligibility requirements.

Through changes in these requirements in the next few years, the social security system is itself reducing the number of employees who can work a relatively short period of time in the private sector and thereby qualify for social security or medicare. This year, workers will need 32 quarters or 8 years of covered employment to receive medicare benefits. By 1990, they will be required to have 40 quarters or 10 years of social security credits to be eligible. As the number of necessary quarters steadily increase, fewer and fewer Federal retirees will be found on medicare rolls in the future.

The administration also implies that former Government workers who are eligible for medicare on the basis of spouse earnings wrongly receive these benefits. But the truth is that these critics have focused on this small group of Federal retirees despite the fact that there are many others who benefit in a similar way. For example, individuals who are employed by charitable organizations and are not covered by social security can receive medicare coverage if their spouses are eligible. We do not believe that it is either accurate or fair to portray Federal retirees as the beneficiaries of unintended medicare payments when they, like other groups, have earned such benefits under the law.

The administration also maintains that universal medicare coverage will help mitigate the financial difficulties of the system. In reality, however, including Federal employees under medicare will only increase the funding problems. In fiscal year 1983, the 1.3-percent payroll tax on the earnings of Federal employees would generate an estimated $619 million in revenue for the Health Insurance Trust Fund. If we assume that the 1 million individuals, age 65 and older, presently receiving civil service retirement annuities were eligible for medicare, and take the average payment and apply it to this group, the additional cost to medicare would be $890 billion.

Moreover, Federal salaries, upon which the 1.3-percent tax would be based, are rising at less than one-half the rate of medicare cost increases. For the period between 1978 and 1980, white collar salaries rose 12 percent, while the medicare benfits costs increased by 27 percent. The disparity between revenue and outlays will only grow as the medicare tax becomes increasingly inadequate to cover the claims made by Federal retirees.

It is possible that under current funding the Health Insurance Trust Fund will be depleted by the end of this decade, according to the report of the National Commission on Social Security. During this same period, Federal retirees will be drawing more from the medicare system than they will be contributing on an annual basis. Rather than moving the Health Insurance Trust Fund toward solvency, the administration's proposal would exacerbate its difficulties.

As we mentioned earlier, the 1.3-percent payroll tax on Federal employees would increase revenues by $619 million while the medicare claims for this group would result in outlays of $890 million. The $271 million shortfall could only be eliminated by requiring that Federal agencies match the employee's contribution to medicare. In order to generate these funds, agency budgets would either have to be increased or vital programs would have to be slashed. In an obvious case of "robbing Peter to pay Paul" universal medicare coverage would drive up to the cost of domestic programs or hamper the delivery of vital Government services.

"Off budget" agencies such as the U.S. Postal Service, would be particularly hardhit by the administration's proposal. The Government contribution would cost the Postal Service at least $170 million in fiscal year 1983. However, the administration has not recommended any means by which this additional money will be raised. Financing the Postal Service's obligation to medicare could very likely result in higher postage rates or even the elimination of Saturday mail delivery.

A further illustration of the adverse impact of the administration's proposal on agency spending is the potential effect on the budget of the Internal Revenue Service where our union represents virtually all the employees. The IRS employer contribution would amount to a $24 million annual expense. Already suffering from a severe budget reduction, the agency could be forced to cut back on the enforcement of our tax laws or even further curtail taxpayer services. In either instance, the U.S. Treasury would be denied vitally needed revenue and voluntary compliance with tax laws would be seriously damaged.

During a period of soaring budget deficits, we are certain that the American people will not support unnecessary Government spending which, in this case, would not produce any additional services. We submit that universal medicare represents a false economy both for the health care system and for beleaguered agency budgets, and must be rejected by this subcommittee.

Besides economic consideration, however, the question of fairness to Federal employees and retirees must also be considered. As the representative of over 120,000 individuals who are present or former employees of the U.S. Government, we can assure the subcommittee that our members are willing to make sacrifices along with other Americans for the economic well-being of our Nation. What is difficult for our members to accept is that for the past decade they have been forced, not asked, to bear a disproportionate share in this struggle.

Attachment A to our statement details the steady erosion in Federal pay and benefits that has taken place over the last 10 years. The addition of universal medicare—as well as the other changes in Federal pay and retirement proposed by the administration—to this list would place yet another strain on the incomes of Federal employees and annuitants.

For example, the President's budget calls for a 5-percent cap on the annual comparability adjustment for Federal workers, well below wage gains reported in the private sector. In addition, premiums costs under the Federal Employees Health Benefit program have been increased by as much as 30 percent. The additional 1.3-percent medicare payroll tax would virtually eliminate any hope by Federal employees that their salaries would keep pace with rising costs.

The medicare tax would fall most heavily on those workers at the lower end of the General Schedule. Attachment B shows the impact this proposal would have on each grade level within the General Schedule. We believe that the tax is an unfair burden on all employees; nevertheless, the fact that the deduction is a flat percentage makes it disproportionately heavy on lower-paid employees. We urge the subcommittee to remember that approximately one-quarter of the Federal work force earns an income which the Bureau of Labor Statistics deems to be at or below the minimum budget for an urban family of four. The additional or regressive tax on the income of these individuals would be a very real hardship in these troubled economics times (see attachment C).

We would also like to remind the subcommittee that the universal medicare plan would bring Federal employees under a system that is part of social security. If this proposal were adopted, Congress would be taking the first step towards universal social security coverage. As you know, a special commission is currently undertaking a comprehensive study of the future of the social security system and will not issue its report until the end of the year. In view of this fact, we believe that it would be premature to implement an aspect of universal coverage before the issue has been carefully studied.

In conclusion, we dispute the administration's claim that universal medicare would improve the solvency of the health care system and would also rectify past inequities. Any initial infusion of funds into the system would only be cancelled by future liabilities. We therefore urge this panel to omit the universal medicare proposal from its recommendations on the budget.

We again express our appreciation to the committee for the opportunity to appear here today. Should you have any questions, we would be pleased to reply to them at this time.

ATTACHMENT A

RECENT CUTBACKS DIRECTED AGAINST FEDERAL PAY AND BENEFITS

The President, in 6 of the past 10 years, has failed to adjust Federal pay to comparable wages in the private sector. These pay "caps" make Federal workers the only group of employees in the country under de facto wage controls.

The pay caps have resulted in lower retirement benefits for Federal retirees because annuities are based upon earnings during active employment.

In 1976, Congress eliminated the 1-percent "add-on" to cost of living adjustments (COLA) on civil service annuities. The "add-on" had compensated for delays in granting the COLA's after the adjustment had been computed.

In 1977, Congress adopted a social security offset for a spouse who receives an earned retirement benefit under a government retirement plan.

In 1980, Congress eliminated the so-called "look back" provision which enabled Federal employees, who retired after a COLA had been implemented, to have this adjustment included in the computation of their initial annuity payment.

In 1981, Congress eliminated one of the two cost of living adjustments on Federal annuities.

In 1981, the Reagan administration began a massive reduction-in-force resulting in thousands of Federal employees losing their jobs.

In 1981, as the first act of his administration, President Reagan announced a retroactive hiring freeze which took promised government jobs away for hundreds of individuals.

In 1982, the Reagan administration instituted a 16- to 20-percent reduction in benefits and a 30-percent increase in premiums under the Federal Employees Health Benefit program.

ATTACHMENT B

1981 COST OF "UNIVERSAL MEDICARE" PROPOSAL TO FEDERAL EMPLOYEES

GS-grade	Medicare tax
2	$122
3	133
4	149
5	167
7	207
9	253
11	306
12	367
13 [1]	421
14 [1]	421
15 [1]	421

[1] Maximum taxable earnings $32,400.

ATTACHMENT C

ESTIMATE IMPACT OF A 5-PERCENT PAY RAISE AND MEDICARE COVERAGE ON EMPLOYEES

Assumptions: October 1982 pay increase 5 percent. Medicare tax 1.3 percent on pay up to $35,400. (1983) Health benefit premium increase 25 percent on Blue Coss/ Blue Shield family high option. Federal taxes with 3 exemptions. State taxes Virginia.

GS-3 $10,235 to $10,747—increase $512—net loss $52.

Increase:	
Health Benefit Premiums	$272
Retirement	36
Life insurance	0
Federal taxes	94
State taxes	22
Medicare	140
	564

GS-5 $12,854 to $13,497—increase $643—net gain $22.

Increase:	
Health Benefit Premiums	$272
Retirement	45
Life insurance	6
Federal taxes	94
State taxes	29
Medicare	175
	621

GS-7 $15,922 to $16,718—increase $796—net loss $19.

Increase:	
Health Benefit Premiums	$272
Retirement	56
Life insurance	6
Federal taxes	218
State taxes	46
Medicare	217
	815

GS-9 $19,477 to $20,451—increase $974—net gain $56.

Increase:	
Health Benefit Premiums	$272
Retirement	68
Life insurance	6
Federal taxes	250
State taxes	56
Medicare	266
	918

GS-11 $23,566 to $24,744—increase $1,178—net gain $137.

Increase:	
Health Benefit Premiums	$272
Retirement	82
Life insurance	6
Federal taxes	291
State taxes	68
Medicare	322
	1,041

GS-12 $28,245 to $29,657—increase $1,412—net gain $69.

Increase:	
Health Benefit Premiums	$272
Retirement	99
Life insurance	6
Federal taxes	499
State taxes	81
Medicare	386
	1,343

GS-13 $33,586 to $35,265—increase $1,679—net gain 145.

Increase:	
Health Benefit Premiums	$272
Retirement	118
Life insurance	12
Federal taxes	577
State taxes	97
Medicare	458
	1,534

Chairman JACOBS. Mr. Rangel has no questions. I think we get your general drift and I think that the committee is sympathetic to your testimony.

And Mr. Gusky, you are the winner.

Mr. GUSKY. Where do I pick up my prize, Mr. Chairman?

Chairman JACOBS. Well, I tell you, Mr. Sombrotto, you came awfully close. I think on my own motion I am going to give a second prize, a Kennedy half. And we have to include him because he represents the letter carriers. And what was it——

Mr. SOMBROTTO. That is me.

Chairman JACOBS. I was saying we have to include you. So that will be—it is one of the three biggest lies. The dollar and the half-dollar will be in the mail today.

All right. This concludes the hearings, and we are grateful to all the panelists for your contribution.

[Whereupon, at 1:25 p.m., the subcommittee was adjourned.]

[The following was submitted for the record:]

STATEMENT OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

The American Association of Homes for the Aging respectfully submits these comments to the Subcommittee on Health of the House Ways and Means Committee concerning the impact of the administration's proposed budget on long-term care. AAHA represents nearly 2,000 not-for-profit providers of long-term care, housing, and housing-related services for the Nation's elderly. Over 50 percent of our member skilled nursing facilities and intermediate care facilities participate in the medicaid program, and many of our members also participate in the medicare program.

The administration plans to reduce medicaid expenditures $2 billion in fiscal year 1983, and the medicare program by $2.5 billion. The magnitude of these budget reductions will clearly and profoundly affect the ability of our member nursing homes to provide quality care to medicaid residents. We see in these drastic cuts the continuation of a process, begun last year, in which the service delivery system in long term care is being reordered to eventually mirror the almshouses that shocked the public consciousness at the turn of the century. Not since the Great Depression have public conditions threatened to abandon the poor, sick, aged, and disadvantaged. We plead before this committee for relief from these budget proposals which are morally and ethically repugnant.

Our position is predicated on the assumption that the Government cannot reform the admittedly expensive public pay programs with a simple meat ax approach, without causing severe disruptions in the lives of thousands of nursing home residents in this country. The effects will not be hidden, nor will they be confined to the ledger sheets of recipient facilities. Rather, the impact will be seen in reduced admissions, reduced quality of life within the facilities, and reduced capacity to provide even the minimally acceptable (by today's standards) levels of care. The cuts in nursing home financing are exacerbated by meat ax chopping of potential alternative programs in home care, social services, and housing. The budget constitutes a statement of abandonment for the frail and vulnerable elderly.

For these reasons, we greatly appreciate the opportunity to speak out on the proposed cuts, and we applaud the scrutiny that these budget proposals are receiving in the Congress.

MEDICARE

The underlying theme in the budget presentation for medicare is one of cost-shifting. The budget proposes a number of steps which shift costs to providers, consumers, and to State governments. What is clear from a reading of the budget proposals is that the administration is more concerned with the short-range fiscal impact of the budget cuts than it is in the long-range consequences.

The cost-shifting through provider screens and integrated percentage cuts to providers will not bring systemic changes in health care delivery, but will lead to policies of cost avoidance. Less providers will serve the poor and disadvantaged and those that continue to do so will either become medicare mills simply pushing people through, or bankrupt. For the individual, cost-sharing will increase his/her disposition of resources leading to eventual pauperization. Medicaid rolls will increase as new, eligible persons spend down to the level of catastrophic protection. States will suffer the pains of disregarding need of raising revenues to compensate for the failure of the Federal structure to promote the public welfare.

For example, the proposed budget would eliminate the Federal matching payments for the beneficiary share of supplemental medical insurance premiums. This appears to be little more than the shifting of additional costs to the states, with the inevitable result that even more money will be drained from the state contribution to actual program services. This particular provision cannot be viewed in a vacuum, but must be seen in the context of the full array of proposed reductions in Federal medicaid contributions. With financial pressures being placed on the States from every aspect of the medicaid program, the termination of Federal matching payments for medicare part B premiums will only accelerate the return of the "warehousing" concept to the realm of policy acceptability. States, burdened by a reduced tax base due to tax reductions and the depressed economy, may be forced into the position of mirroring the Federal Government's meat ax approach to ward off fiscal instability. Despite denials made at various levels within the administration, this can only be done "on the backs" of the indigent elderly and disabled.

Also, the administration has been promoting the concept of maximizing free-market forces in the health care field, and has promised to submit a comprehensive "procompetition" bill this year. While this bill would be timed for fiscal year 1984, we feel it is appropriate to offer our views on the subject, due to the apparent reliance that will be placed on the procompetition approach.

At the outset, we urge the rejection of any "market" proposal which signals a governmental decision to do so much for the elderly, but nothing beyond that point, leaving them to their own devices as part of a Darwin-type scheme. Competition should never become a code word for the dilution of the public sector's commitment to the elderly persons in this country.

As we understand it, the administration is contemplating some sort of voucher system, wherein a person could select the type of health care coverage that best suits his/her medical and economic needs. We must join the ranks of those who have voiced some concern over the ability of the at-risk populations, who are vulnerable because of age or multiple chronicities, to be informed consumers. While the theory behind the voucher has a certain appeal, it is doubtful that many of the indigent elderly and those persons with impaired mobility can make the sophisticated decisions that would be thrust upon them by this proposal. Efforts by the Department of Health and Human Services to educate the users of vouchers would have to be intensive and probably very expensive, without a clear probability of success.

We urge the Congress to avoid the simplistic categorization of the issue as being a matter of either procompetition or proregulation. If we as a Nation do move towards competition, it is inevitable that a final product will contain a blend of these concepts, and thus manifest free-market aspects to create incentives for cost reduction while preserving the Government's historical stake in the process as a defender of the poor, infirm, elderly, and disadvantaged. Towards this goal, we commend the systematic review performed by the Senate Finance Committee during the 96th Congress of proposals to utilize the medicare and medicaid programs to provide catastrophic health care protection. Likewise, we think it would be useful to explore the use of the Internal Revenue Code to create incentives for the proliferation of privately-sponsored care. While we as an association do not endorse either of these options at this time, we do believe they have the potential to free up significant resources, to be used in a more effective manner.

STATEMENT OF AMERICAN CHIROPRACTIC ASSOCIATION AND INTERNATIONAL CHIROPRACTORS ASSOCIATION

INTRODUCTION

The International Chiropractors Association and the American Chiropractic Association are grateful for this opportunity to share with the subcommittee our thoughts on medicare cost-savings proposals. Together our associations represent the 23,000 chiropractors practicing nationwide.

Chiropractic has been a mandated medicare service since 1974. The chiropractic profession, as well as all other health care providers must work with private industry, the Congress, and the administration to resolve the fiscal problems currently affecting our health care delivery system. We are all aware that thundering oratory and self righteous statements alone will not resolve the problem.

All health care providers must be concerned with providing quality care in a cost-efficient manner. The providers of all services covered in the medicare program must be cost-conscious. Those doctors of chiropractic who provide services to medicare beneficiaries, and for that matter in all other programs, must realize the importance of providing quality care within the confines of a system with limited financial resources.

In the 1983 fiscal year budget, the primary medicare savings will be allocated out of hospital expenditures. Thirty-seven percent of the over-all medicare budget will be derived from this cut-back. We have found that institutionalized care, while of a high-quality nature, may not be the best avenue in considering the far reaching financial implications attendant to the high cost of institutionalized care. There are several pieces of legislation before the Congress which offer innovative proposals, as well as new looks at some older proposals. We urge the committee to consider a number of these policy options such as—competition and prospective reimbursement, while carefully considering the inadvisability of radically altering our current health care delivery system in such a manner as to breach the continuity of delivering quality care.

GENERAL RECOMMENDATIONS

We share the administration's, and this subcommittee's concerns with the fiscal integrity of the medicare program. It is clear that something must be done about the unacceptable escalation in the Federal Government's medicare expenditures. Senior citizens, especially those of low-income who are completely dependent on medicare for their health care costs, are increasingly worried that the Federal Government will be unwilling or unable to keep its promise of quality health care for the elderly. Health providers face serious cuts in medicare reimbursement and a medicare administrative system that has become a red-tape nightmare. And the Federal Government is forced to shoulder the burden of a rising medicare price tag that is seemingly paying for less and less of the total cost of health care.

Medicare's fiscal situation has become unacceptable to all involved. In finding solutions to medicare's problems, however, it is necessary to focus on those problems within the context of an overall national health policy rather than short-term fiscal year savings to the Federal budget. We share the concern of many with the use of the Federal budget process to enact substantive changes in the medicare program which, of course, occurred during last year's budget reconciliation. Any proposed changes in medicare should optimally be the subject of full public scrutiny and debate. The Federal budget process does not allow for the deliberation necessary to achieve true medicare reform, nor does it place changes in medicare within the context of a national health policy.

Solutions to the severe fiscal pressures on medicare must instead begin to address comprehensive, long-term reform of the cost-reimbursement system. All too often in the past, attempts to restrain the Federal health budget have focused on piecemeal, seemingly arbitrary alterations in benefits, reimbursement levels, beneficiary cost-sharing, and the like. These attempts have resulted in short-term reductions in the rate of increase in Federal health outlays. But the 17 percent annual increase in medicare and medicaid costs cited by President Reagan in his budget message attests to the dismal failure—and shortsightedness—of this approach. Failing to address the structural problems inherent in the current medicare reimbursement system leaves intact a system fated to corral a larger and larger share of the Federal budget.

Much of the inflation in medicare costs can be attributed to the peculiar dynamics of our current cost-reimbursement system. This system rewards the inefficient delivery of services and contains few effective checks on provider overutilization of services. Furthermore, it fails to correct the overreliance of our health system on acute-care, hospital-based treatment. Clearly, incentives must be built into medicare's reimbursement to reward the efficient institutional provider and to enhance competition between those health practitioners' delivering services. The medicare benefit-package must begin to emphasize preventive services and alternative health care delivered outside the hospital setting. These features are the key to a long-term solution to medicare's fiscal problems.

In regard to ACA and ICA supporting the goals of procompetition it should be noted that in earlier testimony before the 97th Congress we supported the concept of competition yet had reservations regarding some of the specific proposals in the current legislation which has been offered to date. We strongly believe that inter, as well as intra-professional competition, is useful and has a place in the health care community. While several strategies have been offered in terms of providing a legislative program or plan for the health care community it becomes apparent that a unified program fully integrated into a long-term plan is essential.

We therefore support the objectives of the procompetition legislation thus far introduced in the Congress, and we look forward to reviewing the administration's proposals in this area. For inpatient hospital services, which currently account for two-thirds of medicare costs, a prospective reimbursement schedule must be developed to replace the current retrospective cost-payment system. Representative Ron Wyden's bill (H.R. 5084) would hasten the development of such systems.

SPECIFIC RECOMMENDATIONS

We would like to offer the following comments on the administration's proposals to reduce medicare expenditures in the following areas:

REIMBURSEMENT TO PRACTITIONERS

We support the administration's contention that health providers, including chiropractors, who deliver medicare-covered services must bear their part of the burden of reducing medicare expenditures. The administration's proposals to limit increases in the medicare economic index to 5 percent and to update the part B physician fee screen on October 1, would reduce the rate of increase in medicare expenditures for physician and other practitioner fees. This administration's approach is a far more equitable way of treating the physician-reimbursement portion of medicare than we have seen in previous administration's approach which have all to often attempted to single out particular medicare services for wholesale elimination. If providers are to absorb their share of budget cuts, this must be accomplished in a manner equitable to all the covered medicare services.

In considering these two proposals, however, it must be remembered that their enactment is more likely to result in shifting the costs of care to the beneficiary rather than to the health provider. The steady decline in physicians and other practitioners accepting assignment of their medicare claims is likely to accelerate. Instead, a greater portion of the true costs of services will be absorbed by the nonmedicare patient as well as by the medicare beneficiary. In short, while we accept the premise that medicare providers must bear their share of medicare cuts, we must question whether the administration's choice of the means to achieve this goal will in actuality transfer a portion of the cuts to the providers of services.

When the medicare patient is the ultimate payor of increasing costs the issue becomes critical in instances of catastrophic illness. In such cases, the costs are simply beyond the means of all but the most wealthy. A bill for $100,000 for a month's hospitalization and health care for a single month's terminal care is not extraordinary. Therefore, some means must be devised to cope with this situation, either through prospective reimbursement or an HMO pattern which covers total care or through some means of reasonable sharing of costs by providers, patients, and the Government.

Unless some such arrangement is devised, the Government may well bear the total cost, through medicaid, or welfare for the medically impoverished patient or family.

2 PERCENT CUT IN MEDICARE HOSPITAL REIMBURSEMENT

Clearly, the current uncontrolled escalation in the hospital services portion of medicare must be checked. As previously noted in this regard, we think consideration must be given to enactment of long-term reforms to the medicare program. Such a long-term approach would include redesign of the medicare benefit package to emphasize preventive and alternative, nonphysician health services such as chiropractic delivered in noninstitutional settings. For institutional health care delivery, innovative reimbursement systems must be devised to encourage cost-effective and efficient delivery. Representative Wyden's Prospective Hospital Reimbursement bill (H.R. 5084) offers a promising start in this direction.

Across the board cuts in hospital reimbursement will certainly produce an immediate reduction in Federal medicare expenditures but are unlikely to decrease overall national health costs. Instead, those costs not covered by medicare will be shifted to the non-medicare hospital population. Across the board cuts by themselves do little to encourage innovation and efficiency in the delivery of hospital services.

The International Chiropractors Association and the American Chiropractic Association regret that we have no special expertise on hospital reimbursement, owing to the regrettable fact that doctors of chiropractic have been refused the right to practice in most hospitals. But as citizens and occasional patients in hospitals we believe that hospitals can properly tighten their belts and reduce expenditures without damaging necessary patient services.

INCREASES IN MEDICARE COST-SHARING

It has been estimated that over 70 percent of health care utilization decisions are made by the practitioner and not the consumer. The administration's cost-sharing proposals to index the part B deductible to the Consumer Price Index, and the proposed 5 percent copayments on home health services must be viewed in this context. These proposals will shift health costs away from the Federal Government to the medicare beneficiary, thus achieving the intended reduction in the Federal Government's fiscal year 1983 medicare tab. It is unknown the extent to which the Government's expenditures will be reduced in later years by these substantive changes. And it is unknown the extent to which imposition of cost-sharing will affect the elderly's utilization of these health services.

Again, we feel that the proper focus for budget cutting measures is on the provider of services rather than on the elderly beneficiary. Increased competition among practitioners, checks on the overutilization of services by providers, and the development of cost-efficient reimbursement systems is the key to lower medicare costs rather than cost-sharing by the elderly. In order to avoid so impoverishing the elderly by increased medical and health costs that the program merely shifts expenditures from Medicare to medicaid and welfare, the costs must be substantially borne by the providers through effective reduction of their own costs.

MEDICARE CONTRACTORS

The current administrative proposal calls for developing a policy which gives medicare contractors greater responsibility for the identification and reduction of waste. The administration currently estimates that these efforts will bring $330,000,000 in medicare savings in the next fiscal year. The chiropractic profession has noticed that independent adjusters have recently been introduced into the private market by insurance carriers. While the stated purpose is to identify waste, the preliminary results as reported by individual chiropractors around the country point to the curtailment of covered chiropractic services contrary to law and congressional intent. Cost savings are vital but so is obedience to the law. Harassment of the health care provider also becomes an issue. One particular concern which all health care providers must be aware of is the substantial ability of the adjuster to reduce the benefits which should be available to the beneficiary of a health program. This process must be limited to reductions in improper or excessive expenditures not to negation of lawful and legitimate services rendered by chiropractors and other alternate health care providers. While major innovations such as new automated data processing technology are available to medicare contractors, any new system must build in safeguards so that the dominant medical community will not, by boycott, dominate the delivery of health care to the exclusion of all other alternate health care providers such as chiropractors, podiatrists, optometrists and the like.

We are pleased to be able to offer some of these observations to the committee as it takes up the formidable task of trying to resolve a number of these problems. We have attempted to point out potential trouble spots while encouraging innovative proposals. As the Congress considers changes in the structure of our health system it must review the options of expanding freedom of choice and providing incentives to deliver health care more efficiently.

American College of Radiology,
Washington, D.C., February 26, 1982.

Hon. Andrew Jacobs,
Chairman, Subcommittee on Health, Committee on Ways and Means, 1104 Longworth House Office Building, Washington, D.C.

Dear Mr. Chairman: The following comments are offered on behalf of the 16,000 members of the American College of Radiology with reference to proposed changes in Medicare reimbursement for radiologists. The members of the College constitute about 90 percent of the nation's certified specialists in the diagnostic and therapeutic uses of ionizing and other radiation for health purposes.

We appreciate this opportunity to present to the Subcommittee on Health our concerns about the proposal before you. We respectfully request that this letter be added to your March hearing record.

One change proposed by President Reagan in his budget message would reduce the Medicare reimbursement for the services of "physicians in the field of radiology and pathology" to Medicare beneficiaries as inpatients from 100 percent of reasonable charges to the 80 percent specified for other Part B physician services to Medicare beneficiaries.

As we understand it, this change would require congressional action to repeal section 1833 (a)(1)(B) of the basic Medicare act, as amended in sections 932 and 943 of PL 96-499. Section 932 extended the 100 percent coverage to certain diagnostic tests performed by a physician in a hospital outpatient setting within seven days of the Medicare patient's admission to that hospital. It has not yet been implemented by the Health Care Financing Administration. Section 943 requires physician groups to agree to accept Medicare assignment for all inpatient professional fees to retain the 100 percent coverage. It was implemented in July 1981.

The American College of Radiology has contended steadfastly that the services of radiologists are the professional services of physicians and should be regarded by Medicare the same way as other physician services. We were grateful to the Congress for recognizing this in 1965. We did not support the amendment of section 1833 in 1967 and we do not argue philosophically for retention of special treatment now.

In 1967, the rationale for this coverage was advanced by hospitals and carriers, not radiologists. They argued that the convenience to the system in simplified documentation and billing practices would offset the added direct payments. The Part A and Part B trust funds were directed to make any necessary adjustment periodically.

If the Congress now accepts this change, it will add expense and inconvenience for radiology practices. It will also add costs to the processing systems of the carriers and intermediaries. However, the major burden in the change will be placed upon the beneficiaries of the Medicare program. The diagnostic services of radiologists for hospital patients commonly are incurred along with significant expenses for other physician services and hospital care. The therapeutic services of radiologists for hospitalized patients most commonly occur in the treatment of a cancer serious enough to rob the patient of self-sufficiency. In a real sense, these expenses would be shifted to many Medicare beneficiaries in circumstances when they have severely taxed their own resources.

Without access to the figures and assumptions used by the President's advisors, we can make no determinations of the basis for the assertion that this change would save $160 million in 1983. The savings estimated by the Department of Health and Human Services in October for the same change was $100 million. Someone, in the interval, must have revised the estimated total cost of radiology and pathology professional services to Medicare patients from $500 million to $800 million. We are unable to offer any basis for such an expanded estimate. Indeed, since patients receive radiological and pathological services only by referral, the insertion of a 20 percent copayment for the patient should have relatively little impact upon the quantity of services requested by clinicians.

Philosophically, radiologists wish to share the status of all other physicians within Medicare or in any other reimbursement system. However, in commenting upon the budget proposal, which does not deal with philosophy, we are skeptical of the premise that this change will achieve the predicted program savings. Thus, we urge the subcommittee to satisfy itself on this point before imposing added costs upon Medicare beneficiaries.

Thank you for your consideration of our comments.

Sincerely,

JOHN H. HARRIS, Jr., M.D.
Chairman, Board of Chancellors.

STATEMENT OF THE AMERICAN NURSES' ASSOCIATION

The American Nurses' Association a professional association and labor organization representing approximately 170,000 Registered Nurses with constituent associations in all 50 States and the District of Columbia. We appreciate this opportunity to express our concerns regarding the administration's proposed cuts in the medicare program.

As the largest component of the professional health care workforce, responsible for providing the direct care of patients in every conceivable health care setting, we are adamant in our strong opposition of the President's fiscal year 1983 budget proposals. In particular, we are most concerned with those reductions which would cut medicare by $2.5 billion in fiscal year 1983.

Since the early 1950's, ANA has been a strong advocate for extension of the social security system to include health services as benefits for persons who participated during their working years in the social security program. The Association was a frontrunner in the development and passage of the original medicare legislation, and remains committed to the original goals of the programs. Now, more than ever, the ANA reaffirms its unequivocal support for this most important program that provides access to quality health care for over 25 million of our senior citizens. We cannot accept any proposals that will limit the delivery of services to our increasingly large elderly population.

ANA strongly supports the current financing concept of the medicare program as a health "insurance" program rather than a welfare program. Medicare should continue to be financed substantially through the contributions of its potential beneficiaries, thus remaining largely independent of revenues from general appropriations. In our view, the administration's proposals breach the commitment of medicare that, in return for payroll contributions during his working years, an individual would, during his latter years, be eligible for a specified number of hospital days of care, subject only to a nominal front-end deductible. Medicare is not a Government "handout," and should not be treated as such.

We believe that the administration's proposals for fiscal year 1983 do absolutely nothing to address the real problems which underline the crisis which is pervasive not only in the medicare program, but throughout our entire health care financing system. These problems involve unfavorable trends for medicare revenues and payments to beneficiaries which reflect the lack of adequate financial incentives to control costs in the overall health care financing system. In effect, the interrelationships between medicare and other health programs, illustrate the point that when something is "pressed down here," it "pops up there."

For example, a significant number of older people are eligible under both medicare and medicaid. For these people, the result of increased medicare hospital deductibles and copayments is an increase in State and Federal medicaid costs, as medicaid picks up those costs. Given increasingly more limited medicaid budgets, the effect of an increase in "nondiscretionary" spending for medicare deductibles and copayments is to generate pressure on states for further limits on "discretionary" spending such as preventive care, screening, and diagnostic services for children.

In addition, an increasing proportion of medicare are veterans. Many of these individuals have chosen to receive care in community facilities rather than those of the Veterans' Administration. However, as deductibles and copayments increased beyond the capacity of these people to pay (or for hospitals to absorb) increased demand for care in Veterans' Administration hospitals may be anticipated.

As a result, we are philosophically opposed to the central thrust of the administration's proposals which seek to increase the financial burden on the elderly, the population least able to afford increased expenses, while shifting the costs of the medicare program to other health care consumers or other governmental programs. In this statement, we will present the principal reasons that underlie our opposition to the proposed medicare cuts, our objections to specific proposals by the administration, and some alternative ways of reducing medicare costs which we believe are far more equitable and less harsh to the elderly population.

I. OPPOSITION TO MEDICARE REDUCTION

Specifically, we are opposed to the administration's proposals for the following four reasons: (1) the increased financial burden on senior citizens; (2) the impact of last year's medicare reductions; (3) the inadequacy of current medicare coverage; and (4) the failure to address the real problems in the health care system.

(1) Increased financial burden on senior citizens. First, it is important to note that the 1981 Omnibus Reconciliation Act included over $1 billion in medicare reductions. Many of these changes resulted in dramatically increased payments by medicare beneficiaries. For beneficiaries, the reconciliation changes, along with the impact of inflation, resulted in a 27-percent increase in the deductible payment for the first day of inpatient hospital care. The supplementary medical insurance deductible to be paid by the elderly also increased by an alarming 25 percent. Therefore, the cuts made last year substantially increased the out-of-pocket health care costs of medicare beneficiaries.

Second, according to the American Association of Retired Persons/National Retired Teachers Association, in 1980 almost half of all persons age 65 and above, which amounts to more than 12 million people—had an average annual income of less than $5,000. The AARP/NRTA also notes that elderly poverty rates, which had been on a steady decline through 1978, increased from 13.9 percent to 15.1 percent in 1979, making this the largest increase in the elderly poverty rate since the Census Bureau began collecting such data.

Any further increases in out-of-pocket payments would have an inequitable and unfair impact on the elderly, who often live on fixed incomes and can least afford additional expenses. Studies have shown that economic barriers to care through increased charges cause the elderly to forgo needed services. The initial victim is most often preventive care, such as early diagnosis and treatment, essential in the prevention of more serious, and costly, long-term illness. Such an approach is obviously "penny wise and pound foolish."

Clearly, the administration's proposals are grossly unfair and will directly impact on one of the most vulnerable segments of our society, who must survive on fixed incomes. We seriously question an administration which advocates the redistribution of income away from the elderly, to business, the wealthy, and the defense establishment.

(2) Impact of last year's reductions. The ANA favors a moratorium on all further reductions in services under the medicare program. As previously mentioned, last year's reforms made very significant changes affecting both beneficiaries and providers. At the present time, the full impact of these changes have not been honestly examined in any manner whatsoever. Yet regardless of this reality, the administration continues to press for more cuts.

The reductions from last terms was passed just 7 months ago, and implemented just 5 months ago. Hard-pressed State and local governments have been struggling to cope with those enormous cost burdens having shifted to them. We believe that it is entirely irresponsible to embark upon a new round of further massive cuts until the reforms of last year have been fully examined. The Congress cannot be as insensitive to this point as the adminstration appears to be.

(3) Inadequacy of present medicare coverage. While medicare is often viewed as an all-encompassing program covering costs for all care, the National Council on Senior Citizens points out that medicare now pays only 38 percent of an older person's total medical bill. In addition, the Health Research Group found that medicare pays out only 30 cents for every dollar of health care costs incurred by the elderly. While it provides some protection for the elderly, medicare falls woefully short of cushioning the blow of rapidly escalating health care costs. In the face of these statistics, however, the administration continues to press for more cuts.

(4) Failure to address real problems in health care system. For the Nation as a whole, in 1980 health care costs increased by 51.2 percent above 1979. Hospital expenses, which increased by 18.5 percent for the Nation as a whole and 20.1 percent for medicare in 1981 are the major reason for this rapid increase.

The administration's proposals for medicare reductions are clearly in response to these spiralling increases reflected in health care costs generally. We agree that something must be done to hold down health care costs. But, the administration's proposals do nothing to address these problems. They simply shift program costs to both medicare and non-medicare beneficiaries.

The root problem, and most desirable solution, to health care inflation lies with changing the current reimbursement system. Since physicians and hospitals have the ability to influence both their costs and charges, and are, reimbursed for all their expenses, costs will never be controlled unless changes are made in the current reimbursement system. The administration, however, shrinks from these difficult but necessary decisions, and instead opts for taking more money out of the pockets of the elderly.

II. THE ADMINISTRATION'S PROPOSALS

We would like to address the following specific proposals put forward by the administration with which we have concerns:

(1) Copayments for home health care. When the average cost per day per patient in a hospital was $246 in 1981 and the average home health care visit was $24, it makes absolutely no sense whatsoever to discourage efforts that provide health care in a noninstitutional setting. As we have stated, whenever economic barriers to care are erected, service usage declines. Those elderly individuals who cannot afford the copayments for home health will assumably end up in a hospital, or nursing home, thus increasing significantly the costs to medicare.

As the proportion of America's elderly continues to dramatically increase, we believe that it should become a matter of public policy that, whenever possible, our elderly citizens should continue to lead active, independent lives outside of a nursing home setting. The Congress should be creating additional incentives to promote home health care services, not deterrents which discourage utilization of these services.

(2) Indexing the medicare part B deductible to the Consumer Price Index. As previously mentioned, the medicare program provides for less then 50 percent of an older person's medical bill. Shifting increased costs to the elderly who must survive on fixed incomes is grossly unfair considering last year's increased out-of-pocket expenses when the medicare part B deductible was increased by 25 percent. Indexing the medicare part B deductible to the CPI would further exacerbate the adverse impact on the elderly; another increase is surely not necessary.

(3) Employers required to provide health insurance coverage for older workers. The disproportionately high costs of health insurance required for older workers relative to younger workers provides employers with every incentive not to employ and to "unload" older people from their payrolls. To aggravate the situation even further, the older worker may well have a dependent spouse of approximately the same age or older whose health care costs are also factored into the employer's economic equation.

As a matter of public policy, we should be encouraging older workers to remain in the work force, living vigorous, independent lives. This proposal runs contrary to such a philosophy, resulting in increased unemployment and decreased dignity for our elderly citizens.

(4) Two percent reduction in hospital reimbursement. In addition to the fact that this proposal would just shift costs to hospitals, medicare beneficiaries and privately insured consumers, it is an inequitable and indiscriminate approach which deems every hospital "guilty" and penalizes those hospitals which have made major efforts to control or moderate their costs, as opposed to those hospitals which have been relatively inefficient. In the case of the latter facilities some "fat" may be cut, but in the case of the former "muscle and bone" will suffer as essential services are further reduced. Moreover, in the absence of effective professional review, the percentage and related reductions may well serve to stimulate "overservicing" of patients by hospitals to make up for lost revenues.

We are particularly concerned about the ability of public hospitals to absorb this reduction. Besides the fact that we should be encouraging hospitals to treat medicare patients, public hospitals lack a base of privately insured patients which could absorb any cost-shifting to compensate for those medicare reductions. Nor will medicaid absorb the proposed reductions, as most states have cut back in medicaid payments. The proposed reduction will undoubtedly bring many voluntary and public hospitals to fiscal "breaking points." Quite simply, the ability of many of those hospitals to provide free or below-cost care will have been exceeded. No one has hazarded a guess as to what will happen under those circumstances to those hospitals and those people in need of care.

III. ALTERNATIVE PROPOSALS

The ANA recognizes the urgent need to restrain Federal spending and control health care costs. However, we object to those proposals which seek to accomplish these goals through increasing the financial liability of our senior citizens, and simply shifting costs to other payors. Rather, there are several practical alternatives which could produce substantial savings and provide increased revenues to finance health care costs, thereby preventing the entire burdern fo fiscal restraint from falling primarily upon the elderly population.

We would like to suggest the following revenue raising and savings measures as alternatives to the negative benefit cutting approach offered by the administration:

1. Increase the Federal excise tax on alcohol and tobacco, and allocate the funds to the medicare hospital trust fund. There is a reasonable correlation between the use and disease-related aspects of alcohol and tobacco, and costs ultimately incurred by medicare. Present alcohol and tobacco tax rates are grossly disproportionate to sales value compared with the relationship between prices and taxes which existed in the 1950's when the current tax rates were established. Additional tax receipts would obviate the need to fund the trust fund through general revenues, and eliminate the pressure to cut back on medicare outlays.

2. Amend the 1981 tax law so as to generally exclude health care facilities and related organizations from eligibility for the liberalized depreciation and investment credit provisions, including any lease or rental arrangements at any tier. It is undesirable to stimulate and divert capital to the health care area where there already exists an excess of beds and facilities. The annual revenue loss to Federal and State governments is enormous, and will progressively increase. This is a loophole which can readily be closed, with the resultant increase in revenues offsetting the need for further cuts in medicare.

3. Eliminate medicare reimbursement for costs incurred in relation to union activities. HCFA currently allows provider costs incurred in labor management relations to be reimbursed through medicare. As collective bargaining representatives for over 100,000 hospital employees, we are appalled that medicare picks up the tab for management's antiunion activities, including consultant and attorney's fees. In an age of fiscal restraint, it is unconscionable that funds are wasted in this manner. Moreover, Government should remain neutral in labor-management disputes. These expenses should not continue to be reimbursable costs.

Refine present cost reimbursement systems. As we have stated, the current reimbursement system provides no incentive for providers to hold down costs. The implementation of a prospective payment system or a system of fee schedules would provide incentives for restraint, resulting in substantial long-term savings.

Eliminate tax-exempt bonds for hospitals. In 1981, the Congressional Budget Office estimated that $400 million could have been raised in 1980 income tax revenues if hospital tax-exempt bonds were eliminated. Approximately 50 percent of the money raised for hospital capital projects was raised through these bonds. Treasury Secretary Regan recently indicated his belief that tax-exempt financing had encouraged unnecessary hospital capital expenditures. Without question, tax-exempt hospital bonds further escalate medicare reimbursement for empty hospital beds. This loss in Federal revenue should be curtailed.

IV. SUMMARY

In conclusion, we view the administration's medicare proposals for fiscal year 1983 as ill-conceived, short-sighted, and grossly unjust. In failing to address the real problems of the health care system, the administration will simply burden the elderly further with increased expenses, while passing an additional costs to other consumers and governmental entities. We urge the committee to reject the administration's proposals, and to seriously consider our alternative revenue raising and cost-saving alternatives. This irresponsible assault on our elderly citizens cannot be permitted to occur.

STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

On December 5, 1980, the Omnibus Reconciliation Act of 1980 became law. Section 935 of that act raised the medicare reimbursement limitation on outpatient physical thereapy services from $100 to $500—the only increase in the limitation since it was established in 1972. Last year, President Reagan recommended repeal of this increase as part of his budget revision package. Congress refused to enact the repeal, concluding that the increase was necessary to insure the provision of needed physical therapy services to medicare beneficiaries. President Reagan has again proposed repeal of the higher limit in his budget for fiscal year 1983.

The American Physical Therapy Association ("APTA"), which represents approximately 40,000 physical therapists and physical therapist assistants nationwide, enthusiastically supported enactment of the increased limitation and vigorously opposed President Reagan's effort to have it repealed. APTA believes that there are several compelling reasons why President Reagan's proposed repeal of section 935 should be rejected again this year.

First, the increase in the outpatient limit to $500 is an extremely small cost item which will not "bust the budget" if it remains in force. At a maximum, the increase will cost only an estimated $4 million this year and $5 million in fiscal years 1983-1985 or approximately .0068 percent of the $72.7 billion proposed by President Reagan for the health care services budget. It should also be noted that the potential for over-utilization of services or a large increase in costs to the medicare program due to the limit increase is minimal because physical therapy services can be furnished only pursuant to a physician's referral and actual referrals are not expected to increase substantially.

The insignificance of this provision relative to the health care services budget vastly understates its importance to medicare beneficiaries and physical therapists who render services on an outpatient basis. As explained below, a return to the $100 limitation would deprive beneficiaries of needed physical therapy treatments and would prevent physical therapists from furnishing services in and efficient and economical manner.

Second, repeal of the increase would, in effect, legislate outpatient physical therapy services out of the medicare program. If President Reagan's proposal were accepted, no more than $100 in any calendar year could be considered as reimbursable incurred expenses for outpatient physical therapy services furnished by a therapist in independent practice. The $100 could be reduced further by the deductible and coinsurance provisions of part B of the medicare program.

Inflation in medical costs since the $100 limit was imposed in the social security amendments of 1972 has significantly reduced the amount of services which can be provided to medicare beneficiaries for $100. Because physical therapy care generally consists of a series of treatments (as opposed to a single visit), a $100 limit would prevent patients from initiating or completing prescribed therapy programs unless they had access to more costly provider facilities where the $100 limit would not apply. Homebound patients, particularly older Americans and persons who reside in rural areas who do not have ready access to provider facilities would be most adversely affected by a return to the $100 limit because independently practicing therapists are their only source of needed care.

The following examples of typical treatment plans illustrate the gravity of the hardships which will result if the outpatient limitation is cut back to $100.

EXAMPLE 1.—A typical physician prescription (physical therapy treatments are furnished only when prescribed by a physician) for physical therapy threatment for an individual who has suffered a serious strain or hyperextensio of the lower back would provide for three treatments per week for 3 weeks. Each treatment would likely include five modalities: traction, ultrasound, therapeutic exercise, massage, and application of hot packs. Each such treatment would last approximately 1 hour and 15 minutes and would cost about $26. Therefore, the total cost for nine treatments would be $234. under a $100 limitation on outpatient physical therapy services, medicare would reimburse the beneficiary $100, assuming that the $80 deductible has already been covered. The patient would be personally responsible for payment of $134.

EXAMPLE 2.—Assume that an elderly woman has suffered an arm fracture in a fall. The normal physical therapy program prescribed by a physician in such a case would be for three tratments per week for 6 weeks. Each treatment would usually consist of three modalities: therapeutic exercise, ultrasound, and whirlpool. Each treatment would last approximately an hour and would cost around $22. The total cost of the program of care would be $396. Under a $100 limitation scheme, medicare would cover $100 and the elderly woman would be liable for the remaining $296.

EXAMPLE 3.—For stroke victims, it is common for a physician to prescribe thirty-six physical therapy treatments over the course of 3 months. Each treatment would consist of a single procedure: exercise of individual muscle groups, gait training, etc. The normal time for such treatment is generally 45 minutes and typically costs in the neighborhood of $27. The total cost for this plan of treatment would be $972, $872 of which would have to be paid by the medicare beneficiary if a $100 limitation were in effect.

In the experience of APTA's members, the existing $500 limitation allows the majority of prescribed programs of care for most illnesses or injuries to be completed without financial hardship to medicare beneficiaries. Any limit less than $500 would precipitate a manifold decrease in the amount of outpatient physical therapy case that a medicare beneficiary could obtain.

Third, the $500 limitation increases access to physical therapy provided in less costly settings and, therefore, contributes to the overall reduction of medicare costs. There is no dollar limit on reimbursement for physical therapy provided in hospital and nursing homes, both inpatient and outpatient, or in physicians' offices. Physical therapy provided in these settings, however, costs significantly more than when provided by the independent physical therapist on an outpatient basis. By encouraging treatment in less costly settings, therefore, the $500 provision promotes a cost-effective health care system.

APTA strenuously opposed the administration's proposal to repeal the $500 limitation on outpatient physical therapy care. The critical need for the increase was well documented by the 96th Congress and reaffirmed last year when it refused to accede to President Reagan's request that it be repealed. APTA urges Congress to preserve the increase in the dollar limitation which it has laboriously considered, approved, and maintained over the last three sessions of Congress.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES,
Washington, D.C., March 10, 1982.

HON. ANDREW JACOBS, Jr.,
Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. JACOBS: The Association of American Medical Colleges is submitting for inclusion in the March 2nd hearing record its comments on the administration's proposed budget cuts in the medicare program. The association's objections and recommendations address three specific administration proposals: The AAMC strongly opposes the proposal to permit medicare to pay hospital's 2 percent less than the reasonable costs of caring for medicare beneficiaries; the AAMC opposes the proposal to delay updating physician's medicare fee profiles from July 1, 1982 to October 1, 1982; and the AAMC opposes the proposal to limit increases in the medicare economic index to 5 percent.

In addition to representing the Nation's medical schools, the Association of American Medical Colleges represents 71 academic societies, many of whose physician members treat medicare patients, and 328 State, municipal, and not-for-profit teaching hospitals. These hospitals account for 18 percent of the admissions and 32 percent of the outpatient visits provided by all short-stay, non-Federal hospitals. As a result, the administration's physician fee profile and hosptial reimbursement proposals are of vital concern to the AAMC and its members.

PROPOSAL TO REDUCE HOSPITAL PAYMENTS BY 2 PERCENT

The administration, in an effort to reduce Federal expenditures, is proposing to pay hospitals treating medicare beneficiaries 2 percent less than the hospital's real and incurred costs of caring for medicare patients. The AAMC strongly opposes the proposal for seven reasons: It applies to all providers regardless of their efficiency or their past efforts to contain health care costs; it is a denial of retroactive costs already incurred which cannot be avoided by improving hospital operations or reducing expenditures; it fails to recognize significant differences between hospitals in their mix of fixed and variable costs and, thereby, more severely impacts providers with a high proportion of variable costs; it violates the principle of reasonable cost reimbursement which is the fundamental and guiding criteria for paying providers under medicare; it will further stimulate cost shifting to private sector patients and the increase in charges as result of the shift will be most dramatic where Blue Cross and/or other payers used cost-based payment methods; it is most harmful to hospitals with operating deficits and low working capital, thereby, increasing their financial instability; and it will further increase the referral of "bad debt" and charity patients to public general and teaching hospitals.

Each of these weaknesses is significant, together they are an overwhelming indictment of the proposal. Therefore, the AAMC strongly urges the subcommittee to reject the proposal to reduce hospital payments by 2 percent.

UPDATING PHYSICIAN FEE PROFILES

As enacted, the medicare program was designed to pay physicians 80 percent of their usual, customary, and prevailing (UCP) charges for professional services. As presently operating, the program pays significantly less than 80 percent of UCP charges because a 1972 change in the law established a cap on increases in the prevailing fees and because the delay currently involved in updating fee profiles often means 18 to 36 month old data is being used to compute payments. Because of these limitations on 80 percent UCP charges, physicians are increasingly reluctant to accept medicare patients "on assignment." Enactment of an additional 3 month delay in updating fee profiles would further decrease physician willingness to accept assignments and increase the out-of-pocket costs of medicare beneficiaries—both outcomes are undesirable. Therefore, the AAMC urges the subcommittee to reject the administration's proposal to delay updating fee profiles by 3 months.

LIMITATION ON PREVAILING FEES

In a related proposal, the administration proposes limiting the increase in the fee cap from 7.8 percent to 5 percent. This cap was enacted in 1972 to limit prevailing fee increases to actual increases in physicians' practice costs. The economic index has had a significant braking effect on fee increases. Increasing medicare expenditures for physician services are now primarily the result of increased benefit use and increases in the number of beneficiaries.

Physician fees must increase to meet increased practice costs. The medicare economic index is designed to permit fees to increase solely to this limit. The AAMC urges the subcommittee to retain the current 7.8 percent increase in prevailing fees necessary to meet increases in practice costs.

CONCLUSION

The medicare program was created to enable the elderly to have access to appropriate and necessary medical care. It clearly is attaining its objective. The AAMC believes it would be highly inappropriate to limit this access by paying hospitals less than costs incurred, by discouraging physicians from accepting medicare patients "on assignment," and by failing to increase prevailing fee screens to recognize the increased costs of medical practice.

Sincerely,

John A. D. Cooper, M.D.

Statement of the California Hospital Association

On behalf of the 530 member hospitals of the California Hospital Association, we would like to present our views and recommendations on the proposed fiscal year 1983 budget recently submitted to the Congress by the President. Our comments will be confined to a number of issues pertaining to the medicare program which falls within the jurisdiction of this committee.

We recognize that increases in Federal outlays for the Medicare and Medicaid programs are placing significant strains on the budget, which is a proper concern of this Committee. At the same time, and as we have stated before, arbitrary cuts in these critical programs are disruptive to the financial integrity of our hospitals and threaten the continued access to health care services of the beneficiaries of these programs. "Quick fixes" only continue the shift of medicare costs to other purchasers of care, providers, and patients.

We first call your attention to several proposed medicare changes included in the administration's budget. Perhaps the most deleterious proposal, and certainly one of the most inequitable, is the across-the-board reduction of hospital inpatient reimbursement by 2 percent. While the administrative simplicity and saving certainly are appealing, it is these very characteristics which make this proposal inequitable and counterproductive.

An across-the-board payment cut is based on a false premise that all hospitals have similar medicare patient loads, and therefore, would be equally affected by the cuts. The numbers and types of medicare patients vary greatly among hospitals: the impact of a 2-percent cut would also vary. This change would impact the greatest on those hospitals which serve large portions of the community's aged.

Equally disturbing are the disincentives for efficiency and economy which a 2-percent payment cut would entail. Hospitals which sought further savings through more cost-effective administrative and delivery reforms would nevertheless be "rewarded" with the same 2-percent cut as hospitals that make no such effort. Further, there would be an incentive to increase medicare utilization to partially offset the 2-percent cut because marginal costs—the costs of added services—are less than average costs in such institutions.

If this inequitable and counterproductive uniform reimbursement cut is accepted, we estimate it will add between $65 and $85 million to the current $500 million pool of medicare's and medicaid's unreimbursed hospital costs in California. In order to remain economically viable, hospitals must seek recovery of this shortfall from their private paying patients and other third party payers. In California it is increasingly difficult to identify other sources to help finance the care provided medicare beneficiaries. Hospitals with heavy medicare, medicaid, and nonpaying patient loads have virtually no place from which to recover such unmet costs. Thus, a cut of this magnitude would result in service and staffing cutbacks in hospitals, with a corresponding deterioration in access and quality as they seek to reduce their expenses—even though such actions cannot eliminate the deficits that would be incurred under the proposal.

There are several other medicare proposals which would have results quite counter to program efficiency and beneficiary access to quality hospital care. Specifically, we are seriously concerned with the proposed repeal of the waiver of provider liability. We believe that in the exercise of professional judgment and in cases where due care has been taken, providers should not be held liable for the cost of services that in hindsight are judged by medicare to be uncovered or unnecessary. There are presently mechanisms to assure that providers who consistently exercise poor judgment or who have unacceptably high denial rates are disciplined and made accountable. We believe these procedures are sufficient to maintain program integrity and to minimize the burden on administration. This is a far better approach than a return to the practice of demanding patient deposits when the hospital is uncertain as to what services the patient will be found to require in the course of his stay.

We understand that repeal of the waiver of provider liability is related to the development of a new utilization review program not yet described but presumably to be operated by carriers and intermediaries. If the proposed program relies on a system of retrospective claims review similar to that which existed prior to the PSRO program, we would like to record our strong objections. Repeal of the waiver of liability would facilitate the application of penalties under such a program, but it would also permit retrospective reviews to determine whether to pay a hospital that must make its judgment of the needs of a patient when the patient appears in pain at its front door.

Two other reimbursement proposals in the administration's medicare recommendations are of special concern to the members of CHA. Both proposals involve the methods for reimbursing physician services in the hospital setting. First, the administration proposes that payment for the services of hospital-based physicians (generally radiologists and pathologists) be handled in the same manner as for all other physician services. We would like to point out that present procedures which permit such physicians to receive 100 percent of the medicare reasonable charge, rather than 80 percent of such charges, were designed by this committee in 1967 to improve administrative efficiency by allowing hospitals to combine these bills with the medicare cost billings for other services in the departments where they perform their services. Current policy reflects the nature of the arrangements which exist between hospitals and physicians whose entire practice is located in the hospital setting. We believe these combined billing procedures have simplified reimbursement procedures, and that the recent requirement for physicians to accept assignment for these services argues persuasively for the retention of these procedures.

The second physician reimbursement provision would reduce the physician charge limits for services provided in hospital outpatient departments on the theory that physicians do not bear the overhead costs which are normally incorporated in their fees for services in their office practice. While the logic of this argument is compelling, in certain hospitals the fees of ambulatory services teaching physicians sometimes support the costs of these services which are not fully met by medicare and other payers. In these circumstances this proposal could have a very deleterious effect on primary care services provided by hospital outpatient departments. Furthermore, we do not expect physicians to have lower fees for hospital outpatient services than for office services. If they have uniform fees, they are likely not to accept assignment of payment under medicare and the burden on patients for payment is likely to increase.

We oppose the provisions for a change in reimbursement provisions for private rooms. When medicare was enacted, it was recognized that bare cost reimbursement was insufficient to keep hospitals viable. Therefore, hospitals were permitted to profit when a patient, on his own volition, uses a private room. Under the proposal, essentially the entire profit would go to medicare. Medicare would be reimbursed more than cost in these cases.

We have also examined the other proposals included in the medicare portion of the budget submission and we would like to recommend that extension of the medicare tax and medicare eligibility to Federal employees be enacted. Significant numbers of Federal workers ultimately achieve medicare eligibility through working briefly in covered private employment or through the eligibility of a spouse. Applying the hospital insurance tax to Federal workers would bring more equity into the financing of medicare and give all Federal retirees another choice of health insurance coverage.

We also want to endorse the proposal to require continued private insurance coverage of persons who continue working after age 65 in those instances in which the employer offers health insuracnce coverage to all other employees. This proposal could provide significant savings to medicare and it would end what now amounts to a medicare subsidy of private group health insurance which does not bear any of the costs associated with health services for the working elderly.

In general we favor policies which move toward the creation of a more cost-conscious health delivery system and a reduction in inappropriate and costly regulation. Some of the proposals in the administration's medicare package would serve to heighten the cost-awareness of providers and patients through the extension of copayments and reduction in the scope of medicare coverage. These initiatives address the demand for services and can be effective in addressing medicare's overall cost increases.

At the same time, the administration is reportedly considering an expansion of the current program of cost limits under section 223 of Public Law 92-603. We have testified repeatedly that present routine cost limits under section 223 have had an inordinately discriminatory impact on California hospitals. The section 223 methodology does not take into account significant regional variations in medicare hospital utilization. While the 223 cost limits are based on a comparison of hospital per diem costs, the classification of hospitals for comparative purposes does not reflect the significantly shorter lengths of stay, lower admission rates, and higher intensity of services which are characteristic of California hospitals.

The solution long proposed by the California Hospital Association is the regionalization of the section 223 schedule of limits. The limits would be computed according to the current methodology but separately for each of the four census regions. This solution has the advantage of simplicity and conforms to the original intent of Congress expressed by the House Ways and Means Committee that limits should be "based upon comparisons of costs of covered services by various classes of providers in the same geographical areas" (House of Representatives Report No. 92-231, May 26, 1971, U.S. Code, Congressional and Administrative News, p. 5004 (1972)). The total shortfall would be approximately the same as under the current system, but it would be distributed more evenly across various geographical areas.

The Health Care Financing Administration (HCFA) is presently considering expansion of these inequitable cost limits to total inpatient costs supposedly adjusted for individual hospitals case mix differences. We fail to understand how extending this inequitable program can be justified by any benefits to the medicare program. Compounding the present problems in which medicare has not differentiated its payments in accordance with appropriate regional differences among hospitals, the HCFA proposals will not allow for proper adjustment for differences among patients. In our view, this system will create disincentives and impose penalties on our institutions simply because they have markedly reduced medicare lengths of stay and the costs of the medicare program for its beneficiaries in California. We urge you to express your opposition to HCFA and to recommend that the present methodology be revised to reflect appropriate regional differences.

As we seek to address the problems arising from the redefinition of the public commitment to provide access to needed, quality health care for the elderly and the poor, we are concerned with the increasing acceptance by public officials of a two-tier health delivery system. CHA has been supportive of the goal of extending access to health services without regard to economic status. We see this goal being assaulted through arbitrary policies at both the State and Federal level. Nevertheless, we believe that equitable and reasonalbe methods for financing the care provided under medicare and medicaid can be developed which do not compromise the enormous progress which has been made in bringing quality health care to all our citizens.

TAMPA, FLA., *March 2, 1982.*

GENTLEMEN: As I listen to President Reagan campaign promises I heard him say that his administration would never attack the elderly and in violation of his promises he has already cut down on a tremendous amount of benefits to the poor and not fully satisfied with his first cuts his administration has proposed additional reductions of $2.5 billion and an increase in revenues of $619 million on medicare.

To illustrate the terrific burden he has placed on the hard pressed Americans that helped build this Nation a recent survey indicates that between 80 percent and 90 percent of the people he is hurting have not been able to go to a doctor for treatment of ailments or for a mere physical examination because they simply cannot afford the doctor and medicinal costs.

To put it bluntly we just cannot tolerate this attempt to further degrade the senior citizens of our country. We would like to live the rest of our days in dignity.

Thank you.

FERNAND CUEBAS,
Member of the Coalition of Senior Citizens, Board of Directors and Vice President of the Jewish Towers Assn.

STATEMENT OF GEORGE GOULD, CHAIRMAN, LEGISLATIVE COMMITTEE, FUND FOR ASSURING AN INDEPENDENT RETIREMENT

Mr. Chairman, I am George Gould, chairman of the Legislative Committee of FAIR, the Fund for Assuring an Independent Retirement. Ours is a coalition of twenty-five organizations, unions, and associations representing well over 2.7 million active workers and more than 1.6 million retired Federal workers and survivors.

We appreciate the opportunity to express our views to this committee.

As highly as we regard medicare as one of the most enlightened and beneficial programs available to older Americans, we are opposed to the administration's proposal to extend medicare coverage to Federal employees for the reasons I shall enumerate. We therefore recommend that Congress reject the administration's proposal for the following reasons:

1. Extending Medicare coverage to Federal employees would constitute the first step in a predictable continuum of efforts to extend Social Security coverage to Federal civilian employees.

Federal employees, active and retired, are strongly opposed to the concept of merging, integrating, or coordinating Federal civil service retirement with social security. We are convinced that such an action would be contrary to the public interest because it would decimate what is perhaps the Nation's foremost retirement system without providing long-term benefits to the social security program.

Federal workers were warned, in early 1979, by a distinguished Member of Congress, the Honorable Tom Steed: "Don't ever let the camel get his nose under the tent!" That sage advice is no less relevant today, for while social security struggles for survival, the civil service retirement fund has assets in excess of $73 billion, its receipts have been greater than its disbursements in each year of the fund's 61-year history, and the independent board of actuaries has concluded that under the present funding methods the fund will remain solvent for the next 100 years.

Indeed, the view that the two systems should remain separate and independent has been reinforced even more recently by President Ronald Reagan. In a letter address to Congressman Edward J. Derwinski and dated July 20, 1981, assistant to the President Max L. Friedersdorf wrote:

"Knowing of your continued concerns regarding the independence of the Federal Civil Service Retirement Fund . . . I just wanted to assure you that the President explicitly decided that sound national retirement policy requires that these two funds be maintained as separate entiries. . . ."

2. Federal employees are already covered by a contributory health insurance program, which has served the Government and its employees well since 1957.

Employees covered by the Federal Employees Health Benefits program may carry their health insurance coverage into retirement by continuing to pay their share of the premium.

For those reaching age 65 before serving enough years in Federal employment to be eligibile for annuity retirement, the odds are overwhelmingly high that they will have served an abundance of years in private sector employment and thereby qualify for medicare coverage on the basis of covered employment and contributions.

And for the infinitesimally small number of Federal workers who would neither qualify for continued FEHB coverage nor medicare coverage, they are entitled to purchase medicare coverage at the prevailing rate upon attaining age 65.

My point is that there is no appreciable "gap" in terms of the need for health insurance coverage for Federal employees that is in need of filling.

3. The administration's proposal to extend medicare coverage to Federal civilian employees rests upon assumptions which are at best questionable.

The justifications, as stated in the fiscal year 1983 budget message, are:

a. "More than half of retired Federal workers over 65 qualify for health insurance coverage on the basis of spouse earnings or modest periods of employment in the private sector, even though they did not pay the health insurance tax as Federal employees."

In response to this free-ride implication in regard to medicare health insurance, I would point out that no Federal employee receives a social security benefit that has not been earned by meeting the terms of existing law—whether earned through "modest periods of employment in the privte sector" or as the spouse of a covered worker who has paid the scheduled FICA tax. If the qualification formula is considered to be too liberal, the Congress can do with medicare exactly what it did with the minimum benefit last year—tighten up on the eligibility requirements. But until the formula is changed, Federal employees should not be singled out for abuse when they have met the requirements of existing law.

b. "Universal eligibility for medicare among Federal workers would be established by requiring payment of the health insurance tax."

In answer to this expressed desire for universal medicare coverage, I have pointed out earlier that Federal employees have a health insurance program that they can continue into retirement. Therefore, the desire for universal medicare coverage would appear to be nothing more than the first step in a campaign to make social security coverage universal—a move opposed by the President himself.

c. "This change would improve the solvency of the health insurance trust fund and provide more equitable treatment of Federal workers ($619 million in 1983 revenue increase)."

In responding to this point we are in all probability now addressing what the administration considers to be the "bottom line," the matter of increasing revenues to the health insurance fund.

I would point out, Mr. Chairman, that while social security benefits are tax-free, Federal civil service annuities become fully taxable as soon as the retired worker recovers as much in annuity as he or she has contributed to the retirement fund.

Estimates vary as to the amount of Federal annuity that is returned in Federal income taxes: The independent actuarial firm of Edward H. Friend and Company estimates that the average Federal retiree returns 10 percent of annuity in Federal income taxes; the Joint Congressional Committee on Taxation estimates 17 percent.

When either of these estimates is applied to actual disbursements of $15 billion from the retirement fund in 1980, the most recent year for which published data are available, the results are as follows:

Under the Friend estimate, the amount of annuity returned as Federal income taxes is $1.5 billion per year; under the Joint Committee estimate, $2.55 billion per year.

In contrast to these figures, the administration estimates that the health insurance fund would gain $619 million per year if Federal employees were covered by medicare.

My point is this: Retired Federal workers are already paying more—considerably more—in Federal income taxes than active workers would be paying in health insurance taxes. And if the salaries of active workers were reduced by an additional 1.3 percent in the form of a medicare tax, after the President has shaved a 15 percent comparability pay raise to 4.8 percent percent by imposing a "pay cap," I would simply raise the question: How much is enough?

Mr. Chairman, this completes my testimony. I would be pleased to respond to any questions the subcommittee might have.

Thank you.

STATEMENT OF THE HOME HEALTH SERVICES AND STAFFING ASSOCIATION

Mr. Chairman and members of the subcommittee, I am John B. Smith, Chairman of the Home Health Services and Staffing Association. The association represents 18 investor-owned, tax-paying companies which provide home health care and supplemental nursing services throughout the country. Together the association's members have over 800 offices in 45 States. In addition to providing a small, but growing share of services to medicare beneficiaries, companies like the association's members provide a significant majority of the care provided to private pay patients.

We appreciate the opportunity to submit this statement to comment on the administration's proposed 1983 budget as it relates to home health care provided under medicare.

1. SINGLE REIMBURSEMENT LIMIT FOR ALL HOME HEALTH AGENCIES

The administration proposes to save $18 million in 1983 by setting a single medicare reimbursement limit for visits by hospital-based and freestanding home health agencies. The association supports this proposal. We do not believe that the provision of home health services by a hospital-based agency is legitimately higher simply because those services are based in an institution. Rather, we understand higher rates to result from the inappropriate allocation to the agency of certain hospital overhead costs which have nothing to do with in-home services, that is, a cafeteria in the hospital building.

2. FIVE PERCENT COINSURANCE FOR ALL HOME VISITS

The administration proposes to require coinsurance on medicare home health services. The estimated Federal savings would be $35 million in fiscal 1983. The administration's budget materials use the term "coinsurance." As we understand the proposal, what is intended is a 5 percent copayment. In other words, medicare beneficiary copayments would be computed on a per-visit basis; it would not be applied to the total volume of services which a beneficiary receives in any particular period. We are told informally that the Department of Health and Human Services estimates that this copayment would be $1.90 per visit.

The association opposes this proposal.

The administration cites a recent study by the General Accounting Office to support a conclusion that 27 percent of home health visits covered by medicare were "questionable." Whatever questionable may mean to the General Accounting Office, we submit that it does not mean that 27 percent of home health visits would prove to be unnecessary or unreasonable under applicable medicare guidelines if examined closely.

In any case, the administration contends that the per-visit copayment will deter unnecessary home health services without deterring necessary home care. The administration cites no evidence for its view, and we suspect there is none. To the extent that the copayment acts as a deterrent, we expect that its effect would fall equally upon needed and unneeded visits. It is wishful to think that the deterrent effect of the copayment will be so precisely fashioned as to fall only on visits which are in fact unnecessary.

A second objection is purely practical. Because home care is delivered in the home, and not in an institution, we believe that a copayment for home health will be extraordinarily difficult to administer. The administration does not explain whether the visiting professional, whether it is a registered nurse, a therapist, or a homemaker-home health aide, should collect the $1.90 each time a medicare beneficiary's home is visited. In 1979, the most recent year for which figures are available, 19,159,000 covered home health visits were made to medicare beneficiaries. If a copayment is to be made on the occasion of each of these visits, we invite the committee to contemplate the difficulty and redtape that will ensue by requiring the tens of thousands of visiting professionals to account for the multitude of $1.90 payments they will be receiving.

If, on the other hand, the visiting professionals are not to collect the copayment, but instead, it will be billed by the medicare contractor to the beneficiary, we again invite the committee to contemplate the administrative costs of collecting the millions of small claims that would be involved.

In short, the administration's proposal: Is unlikely to deter unnecessary services; is likely to deter needed services just at the time when more home care is needed to cut unnecessary hospital stays; and probably will incur very substantial administrative costs, complications, and frustrations for medicare beneficiaries, contractors, and providers.

3. ELIMINATE WAIVER OF LIABILITY

The administration proposes to save $10 million in fiscal year 1983 by eliminating the waiver of provider liability for uncovered medicare services. The committee should note that the administration proposes that providers will not be paid, not in cases where they knew the services were uncovered, but in cases where in perfect good faith, they provided services, submitted claims to the medicare contractor, and were paid by the contractor. In other words, both the medicare contractor and the provider will have proceeded on the basis that submission and payment of the claim was proper. It seems plainly unfair to ask providers to foot the bill for mistakes of the government and its agents.

If the medicare system were simple, clear, and easily understood by contractor employees, providers, and beneficiaries, perhaps the administration's proposal would make some sense. In fact, however, the medicare program is an immensely complicated one, with hundreds of pages of Federal regulations and thousands of pages of medicare contractor manuals and guidelines. It is not run from Baltimore by a single unit of the Health Care Financing Administration. Rather, it is operated under Federal regulations and guidelines by many medicare carriers and intermediaries, each of whom has its own idea about how to make coverage decisions and process claims. If the provider in good faith provided a service which was not in fact a covered service, it was because he had not been appropriately informed by the contractor or by medicare of what the rules actually were. Given the real and complicated world of the medicare system, it is not surprising that this occasionally happens. In fact, the very modest estimate of what the administration hopes to save in fiscal 1983 suggests that it is a very small problem indeed, compared to the size of the medicare program.

Moreover, we suspect that the program will incur significant administrative costs in dealing with provider inquiries about the status of coverage and claims processing much more frequently than is now the case.

4. MEDICARE CONTRACTORS' BUDGET

Especially short-sighted is the fact that the medicare contractor budget has been held at the same level for 1983 ($704 million) as it is in 1982. Yet in the proposed 1983 budget alone, the administration is proposing steps that will make the contractor's job more complicated and more expensive, not less. Moreover, in spite of all the hue and cry about fraud and abuse in home health and other parts of the medicare program, the level budget inevitably means a reduction in oversight in order to make up for increased costs of claims processing. And based on our experience with the regional intermediary program for home health agencies, the administration's claim that program efficiencies will be increased by the application of a new automated data processing is at best merely hopeful and, at worst, misleading.

Holding the contractor budget steady invites more fraud and abuse, invites less educational effort with providers and beneficiaries, and therefore invites more confusion, delay, and dissatisfaction on the part of beneficiaries, providers, and contractors alike. This will assure that the medicare program will be more expensive, not less expensive to operate.

5. ADMINISTRATIVE COST REDUCTION

The budget proposes to save $15 million by a personnel reduction of 683 full-time equivalents at HCFA. This has a particular bearing on the efficient administration of the home health service program. This is because much of that total personnel reduction is to come from the Office of Direct Reimbursement, a division of HCFA which directly processes claims for freestanding home health agencies and other providers.

With the support of home health providers, Congress mandated that the Health Care Financing Administration appoint regional intermediaries for home health agencies, and HCFA has proceeded to do so. However, in spite of clear statutory authority and legislative intent, HCFA has at the same time unilaterally—and as we are contending in Federal District Court in Washington, D.C., illegally—ended the Office of Direct Reimbursement as an optional intermediary for home health agencies. Terminating ODR has been unaccompanied by any analysis showing that the end of this national option for freestanding agencies would result in more efficient operation of the medicare program. Here again, we suspect that HCFA's decision to fail to provide a national intermediary option, as presently represented by the Office of Direct Reimbursement, will result in greater program and administrative costs for medicare. Even though these administrative costs will be shifted to the budget of the contractors, this is simply a sleight-of-hand which fools no one who has paid any attention to the matter and which benefits the taxpayer not one whit.

There is a very simple way out of this dilemma which would allow HCFA to cut its own staff—if it so decides, but still retain the efficiencies of a single national intermediary. That is, to work out a solution which would allow a home health agency the option of choosing one other intermediary as an HCFA. That optional "national" intermediary could also be designated by HCFA. We do not propose the continuation of the right of the home health agency to nominate its intermediary. We are not saying that it is absolutely necessary, from a practical point of view, that the national intermediary be an office of the medicare program, although we think that that is required under current law. We are saying that the program can be run more efficiently if there is the option of a single national intermediary.

6. SUPPLEMENTAL PROPOSALS

In our closing coments, let us make two suggestions for your consideration as you examine the administration's proposals for the medicare budget. We believe that significant program dollars can be saved by encouraging the use of home care for appropriate patients in lieu of in-patient hospital days. Nowhere in the administration's budget do we find this sort of program savings suggested. This is probably because of the inherent proinstitutional bias of the medicare program. Clearly, home care is not appropriate for all patients in the hospital. It is not possible to shorten every single hospital stay just because of the presence of home care. Nevertheless, numerous case studies have shown that home care can save hospital costs. The order of magnitude of these savings, when applied to the medicare program as a whole, is much larger than the relatively modest amounts which the administration believes it can save through its own proposals.

Second, we suggest that the committee eliminate the requirement that non-medicare patients pay the same amount that medicare pays for its beneficiaries. Current law has the effect of increasing the overall cost of home health care by requiring agencies which serve both private pay and medicare beneficiaries to charge all patients the medicare cost level, which is always higher because of the added cost of doing business with the medicare bureaucracy. It is perverse of the medicare program to have the effect of driving up the costs of health care for those patients for whom it is not responsible. At worst, our proposal would not incur any additional medicare costs. In fact, it would probably reduce program costs because agencies would no longer have to resort to establishing a separate entity to provide care to private pay patients in order to charge non-medicare patients a lower rate. Allowing both types of patients to be served from the same agency, but at different rates as determined by the costs of providing the services, would result in total overhead being spread over larger number of cases, and therefore in reduced costs to the medicare program. In sum, we believe that our proposal would have benefits for both the medicare program and for private pay patients, and we urge the committee to consider it favorably.

7. CONCLUSION

To summarize our position, Mr. Chairman, we support the single set of cost limits for home health visits, if necessary, with appropriate adjustment of hospital cost allocation requirements. This would acknowledge a fact which many seem to ignore: home care services are not delivered to patients in institutions.

As to the other proposals made by the administration, we urge the committee not to adopt them for the reasons expressed above. We would be happy to work with the committee and its staff as you consider the administration's proposals further.

STATEMENT OF THE HOSPITAL ASSOCIATION OF NEW YORK STATE

The Hospital Association of New York State (HANYS) represents 350 voluntary and public hospitals and related health care facilities in New York State.

In his budget for fiscal year 1983, submitted to the Congress on February 8, President Reagan proposes cuts in the medicare program of approximately $3 billion. It is estimated that the impact of these cuts on New York State will be in excess of $220 million. While we fully understand the need to control Government spending, we are concerned with the methods being pursued by the administration, in that they are arbitrary and indiscriminate and fail to recognize what is being done in individual states to control health care costs.

Since 1969 New York State's hospitals have operated under the most restrictive cost containment program in the Nation. While savings have been achieved—according to one study, $2.3 billion in medicaid since 1975, half of which accrued to the Federal Government—costs to the system have been incurred as well. Over the last 5 years, aggregate operating losses to New York's public and voluntary hospitals have exceeded $1.25 billion; as a result, services have been curtailed and facilities closed due to bankruptcy.

By a combination of voluntary and mandatory cost containment efforts, we in New York have removed the fat from the system. According to preliminary statistics from an American Hospital Association survey of nationwide per diem costs, the rate of increase for voluntary hospitals in New York State was 10.4 percent for 1980 compared to a national increase of 12.7 percent. The cumulative increase in per diem costs for New York State's voluntary hospitals was 44.5 percent in the 5 year period between 1976 and 1980 compared to a nationwide increase of 60.7 percent during the same period. In each of those 5 years, New York State registered a rate of increase which was below the rate of increase for the Nation as a whole. In addition, the adjusted 1980 per diem cost of $244.55 was for the first time less than the national adjusted per diem which in 1980 stood at $245.74.

The financial health of the hospital industry in New York State today is not good. The combination of Federal and State reductions in financial support have resulted in a situation where: 80 percent of voluntary and public hospitals end their fiscal years with net operating losses; facilities have closed, not because they are no longer needed, but because they are not financially able to continue in operation; services have been curtailed and staffing patterns reduced, where possible; and generally, those hospitals that manage to continue in operation, while incurring significant deficits, have done so through the implementation of short-term solutions--such as delaying routine improvements to physical plant and short-term borrowing at high interest rates to create working capital for the provision of health services—with serious long range implications for both the Government and the future viability of the entire health care delivery system in New York State.

We in New York who have practiced cost containment, both on a voluntary and mandatory basis, long before it became a national vogue, cannot now be expected to bear further reductions without cutting into the muscle and bone of the health delivery system of our State. In particular, we must note our opposition to the following proposals to reduce medicare expenditures: the proposal to cut medicare reimbursement to hospitals by 2 percent across the board would cost providers in New York State approximately $60 million. This proposal is particularly objectionable because of its arbitrary nature and lack of any recognition of the ability of individual hospitals to accommodate such a reduction. Those hospitals which serve a large number of medicare patients—in New York State approximately 40 percent of patient days—would be particularly hard hit. In addition, since New York State's "charge control law" limits private rates, hospitals would have little, if any, opportunity to shift costs to other payors. Finally, this proposal is also objectionable because it would establish medicare reimbursement on a cost minus system; repeal of the medicare provider waiver of liability will result in the retroactive denial of claims for services rendered patients who are presumed eligible for medicare but are later found ineligible. Payment is now made to an institutional provider for such services if the hospital could not have reasonably known that payment would be disallowed for these items or services. Hospitals and other providers are presumed to have acted in good faith if their total denial rate on medicare claims is less than certain prescribed levels. The projected savings of $10 million for this proposed change is insignificant. The current statutory provision is equitable to providers and contains appropriate safeguards against abuse—it should be maintained; and, since its inception the PSRO program has offered an appropriate mechanism for peer review of utilization of hospital services which takes into consideration quality of care standards. While we will not judge the effectiveness of the program on a nationwide level, and feel that many of the benefits of the program are not economically quantifiable, we feel that New York State's PSRO program, as well as the PSRO programs in certain other states, has proved successful. Therefore, we are opposed to any elimination of the PSRO program and feel that any projected savings as a result of such elimination might be offset by changed utilization patterns.

There are several other medicare proposals with which we are concerned and with which we will be providing further information in the near future.

Generally, in considering medicare reductions, this committee must take into consideration the efforts of individual states to control costs, as well as the ability of individual facilities to accommodate cuts, and thus provide appropriate offsets. It is important to reject the arbitrary assumption that all hospitals operate in the same environment and can thus accommodate the same across the board cuts. The fiscal viability and long range stability of the hospital industry cannot be maintained by year to year cuts in Federal support and the resultant uncertainty it creates.

As alternatives we suggest the committee consider the following: the establishment of prospective reimbursement under medicare would create efficiency in the system and provide incentives for cost containment; the rate of increases in the cost of living adjustments under the social security program need to be reexamined; the rate of increase in military spending needs to be scaled back and adjusted in terms of the Nation's ability to accommodate such spending; tax reductions enacted last year need to be reexamined and additional efforts to raise revenue, without placing an undue burden upon the public, need to be pursued; and, alternative budget proposals, such as that offered by Senator Ernest Hollings, merit serious consideration.

MONTANA SENIOR CITIZENS ASSN., INC.
Helena, Mont., March 5, 1982.

Representative ANDREW JACOBS, JR.,
Chairperson, Subcommittee on Health, House Ways and Means Committee, Washington, D.C.

DEAR REPRESENTATIVE. JACOBS: The Montana Senior Citizens Association (MSCA) is outraged at the cuts in the medicare and medicaid programs that President Reagan is proposing. Inflation is already killing our senior citizens, without the help of the Reagan administration. Health care costs rose 15 percent in 1981, with hospital care up 18 percent. In Montana, hospital care rose 22 percent. If the Reagan proposal is accepted, a senior will have to pay a $600 out-of-pocket expense for a 10-day hospital stay, out of a $300 average monthly social security check. The math just does not balance.

The 5,000 senior citizens who belong to MSCA have been holding statewide meetings to express their frustrations. I have enclosed press clippings from some of those meetings for you to look at.

Montana seniors are also circulating a petition throughout the state in opposition to these cuts. The Montana Congressional delegation have received hundreds of signatures, and letters, and Montana senior citizens will not rest until these proposed cuts have themselves fallen victim to the Reagan axe.

The Reagan proposal will impose unreasonable financial burdens on American senior citizens, which will in turn threaten their health. The Montana Senior Citizens Association asks you, in your recommendations, to consider not only the health and well-being of our senior citizens, but their dignity. There is no dignity in poorhouses, welfare, and soup lines.

Enclosed you will also find a letter from one Montana senior citizen, Thomas Brophy, from Butte, Mont. He has very eloquently addressed the feelings of Montana senior citizens.

The following statements are quotes from four Montana senior citizens who feel they are being treated very unfairly, and who fear for their future if the Reagan medicare/medicaid cuts are accepted by Congress.

"How much persecution are we senior citizens to take, financially?" Elton Barnes, Helena, Mont.

"After all these years we're lived, and the money we've put into the system, seniors shouldn't have to suffer like this, and lose our property, when we are hospitalized. Nor should our children have to lose their home or assets to pay for our care. I think we have earned our care." Margaret Arps, Belt, Mont.

"They're dealing entirely with statistics, they're not dealing with people, with human beings." Everett Woodgerd, Missoula, Mont.

"This is a disgrace. We've contributed the best years of our lives to make this society what it is today. We're earned the right to a decent life—we're not asking for something excessive." Jake Franks, Park City, Mont.

Sincerely,

CHARLES A. BANDEROB,
President, Montana Senior Citizens Association.

BUTTE, MONT., *February 25, 1982.*

CONGRESSMAN PAT WILLIAMS,
U.S. House of Representatives, Washington, D.C.

DEAR PAT: Yesterday I and my wife, Marie attended a meeting of the Montana Senior Citizens at which some 200 elderly from this community were present. These people are angry, depressed, confused, and frustrated by the proposed radical cuts in medicare programs. Some who are most interested you will not hear from for the purchase of a 20-cent stamp is an important consideration. It is heartless to see the poor become poorer and the middle class become near-poor; is this what we have labored for all these years?

I am writing you to strongly protest these proposed cuts in medicare.

It came through loud and clear at this meeting that we must look to our elected congressional representatives to stop this madness of Ronald Reagan and David Stockman—it is you to whom we look to make the laws that will assure equity to the elderly in their old age. We beg you to do all in your power to turn this proposal around so we do not head back into the dark ages when the elderly could not buy medical coverage because the private insurance companies only cared for healthy balance sheets and had no interest in healthy bodies that contribute so much to peaceful and healthy minds. I feel that the lives of our senior citizens in their sunset years should be as peaceful and meaningful as the sunrise.

Pat, we need your help! We must turn this mad attack on the social programs around.

There was a low-income lady under 60 who has worked under the "green thumb" program and at the meeting yesterday she expressed grave concern over the cutting of that program; the money she earned was small but most important to her these people need representation in Congress at a level never before deemed necessary.

We do not want to see a return to the soup-lines and pest-houses for our needy and aged citizens.

Very truly yours,

THOMAS C. BROPHY.

[From the Great Falls Tribune, Mar. 4, 1982]

SENIOR CITIZENS PROTEST PLANNED CUTS

(By Peter Johnson)

About 100 Great Falls-area senior citizens showed up at a Wednesday meeting to learn more about—and to protest—proposed Reagan administration cuts in the medicare and medicaid programs.

Representatives of the Montana Senior Citizens Association explained the proposed cuts, while local residents provided the complaints. They were busy after the meeting signing petitions and writing letters to President Reagan protesting the proposals. One senior citizen scrawled a letter asking the President to have a heart because senior citizens aren't wealthy.

Margaret Arps of Belt, who led some of the discussion, said, "The cost to seniors is going up to the point where we can't afford to be sick."

"After all these years we've lived, and the money we've put into the system, seniors shouldn't have to suffer like this, and lose our property, when we are hospitalized," she said. "Nor should our children have to lose their home or assets to pay for our care.

"I think we have earned our care."

One proposed Reagan medicare proposal, called "cost sharing." would require senior citizens to pay 10 percent of their daily hospital bills up to $2,500 beginning in 1984. Another would deny medicare protection to persons over 65 still working, while a third proposal would eliminate a review program that monitors hospital and doctor bills to prevent overcharging.

Two Reagan Medicaid proposals also had the senior citizens upset.

One would give States the option of garnishing the property of senior citizens to pay for their nursing home care, while the other would permit States to charge grown children for their parents; nursing home care.

Ruth Nelson, 64, 519 2nd Ave. SW. said she is concerned that she and her husband might have to go on welfare if they had to support her 87-year-old mother's nursing home costs. Her mother's railroad widow's pension of about $200 a month already is going to nursing home costs. Nelson said, and is now supplemented by Federal aid of about $900 a month.

While she and her husand are getting along fine now on their own railroad pension, Mrs. Nelson said, the proposed change might result "in having three of us on welfare instead of one. That doesn't make any sense."

Another woman complained that medicare doesn't cover full hospitalization costs currently, so seniors would "be up a creek" if new program cuts are approved.

Fred Brannon, 520 6th Ave. N., suggested seniors remind representatives that they're voters when they write letters protesting the cuts.

Rene Brererton, a staff employee for the Montana Senior Citizens Association, agreed with both points. One of six Montana voters is older than 65, she said.

Brererton also said Montana doctors don't accept 80 percent of medicare's recommended fee schedules, with senior citizens required to pick up the difference. She urged senior citizens to negotiate rates ahead of time with doctors.

[From the Missoulian]

SENIORS MOBILIZE TO DEFEAT CUTS IN HEALTH PROGRAMS

(By David Roach)

All boos.

That was the unanimous response President Reagan's plan to cut $4 billion from medicare and medicaid got from some 45 area senior citizens Thursday.

And that's the message they pledged to send to Congress and the White House, through letters, telephone calls and petitions.

Aiming for a citizens protest akin to the one that killed social security cuts last year, the elderly residents will urge their relatives, neighbors and friends to join them.

The senior citizens had gathered in Missoula Thursday for one of eight meetings being put on statewide by the Montana Senior Citizens Association.

The organization and its supporters hope to build local opposition powerful enough to stop cuts in medical-aid programs and other social programs.

For the elderly residents who attended, the issue is fairness. The Reagan proposals, they said, aren't fair.

"The public seems to think that medicare covers all of your health care expenses," said Rita Albano of Missoula, who is helping the state group organize local senior citizens.

"If you're a senior citizen, you know that's not true," Albano said.

She and others said Thursday that the medicare cuts will hit the elderly hard during economic times when it's difficult enough to make ends meet.

If the White House would cut benefits for those at the top of society as well as those at the bottom, "then I can live with that," said Larry Ryan Sr. of Missoula.

Ryan is past president of Montana's Retired Railroad Veterans Association. A 21-percent cut last year in pensions for railroad retirees was recently reduced to 15 percent by Congress after a public outcry.

"We want fair treatment," Ryan said, "That's all we're asking."

Everett Woodgerd of Missoula, president of the Montana branch of the National association of Retired Federal Employees, said the cuts are being proposed without thought to their effect.

"They're dealing entirely with statistics," Woodgerd said. "They're not dealing with people, with human beings."

Already under fire by some congressmen, the White house proposal would reduce medicare and medicaid spending by $4 billion.

Even with those cuts, Federal outlays for the two programs will reach $72.5 billion in fiscal 1983 and $79.6 billion in fiscal 1984, according to the Office of Management and Budget.

Medicaid is a Federal-State program that pays medical expenses of eligible welfare recipients, while Medicare pays for health-care expenses of people over the age 65.

Among other changes criticized by the senior citizens, the White House wants to:

Allow the part 2 deductible paid by medicare beneficiaries to rise with inflation by indexing it to the Consumer Price Index.

Require medicare beneficiaries to pay 5 percent of the cost for each home health visit, as a deterrent to unnecessary visits.

End special medicare payment provisions for radiologists and pathologists.

Delay by one month eligibility for medicare when a person reaches age 65.

Permit states to require children of institutionalized medicaid benficiaries to pay part of the cost of their parents' care.

Allow states to place liens on property before the death of an institutionalized beneficiary to facilitate recovery of medicaid costs after the person's death.

Both of Montana's U.S. Senators oppose the changes, and aides who attended the Thursday meeting empahasized that:

In a statement read by his Missoula office field representative, Carlene Nimlos, Max Baucus called the cuts a "shellgame" that ultimately * * *.

Baucus said the administration is ignoring billions of dollars in medicare and medicaid fraud by doctors and hospitals.

Holly Luck, a Washington staff member for John Melcher, said the Senator called the cuts outrageous.

She also pointed to a 100-percent pro-elderly rating recently given Melcher, who is up for reelection this year, by the National Council of Senior Citizens.

In a Thursday press release, Melcher said parts of medicare should be expanded, not reduced. Budget cuts instead should be made in foreign aid, outside consultants' fees, and government travel and advertising expenses, he contended.

[From the Billings Gazette, Feb. 14, 1982]

ELDERLY MARCH TO MELCHER WITH MEDICARE PROTEST

(By Laurie LeMauviel)

About 100 Billings seniors signed a petition and planned other action in protest of President Reagan's proposed medicare and medicaid custs, at the Montana Senior Citizen's Association meeting, Saturday, topping the meeting off with a visit to Senator John Melcher, D-Mont. who was in Billings.

The meeting, at the Labor Temple, was originally called to plan stategy for fighting the cuts—but more direct action resulted. Charley Banderob of Ballantine, MSCA president, quickly drew up a petition, opposing medicare and medicaid cuts and asking Congress to "call a halt to all discriminatory cuts and begin restoring buying power and equality to the American people."

The seniors decided to meet again at 2 p.m. March 13 at the Labor Temple, 24 S. 29th St., to plan a local demonstration against the cuts, to be coordinated with the national day of senior protest scheduled for April 30. The group was encouraged to get friends to come to the next meeting and help with the petitions.

Some of the medicare-medicaid proposals, already approved by Reagan, that have upset seniors, include: charging medicare patients 10 percent a day for the second to 60th day of a hospita stay; having employers continue private health insurance coverage for those who continue wo work after age 65; allowing states to require families of medicaid patients in nursing homes help pay the bills; limiting medicare payments to radiologists and pathologists to 80 percent of normal charges; and permitting States to charge the lower-income medicaid patients for part of their health care, such as doctor visits and hospital stays.

The proposals drew rage from some members of the group. "This is a disgrace," said Jack Frank. "We've contributed the best years of our lives to make this society what it is today. We've earned the right to a decent life—we're not asking for something excessive," said Frank.

Another woman complained that her 86-year-old mother had been plagued by medicaid investigators from Helena who wanted her to make sure she didn't misuse her $1 per month medicaid allotment, an amount intended, she said, to cover the cost of prescriptions under the present program.

When the meeting was over, about 25 percent of the group made an impromptu visit to Melcher, who was holding a meeting at the Northern Hotel. Melcher was fielding questions about the economy and gas prices, as the group trickled in. Most of the seniors stood at the back of the room.

A half-hour later Banderob was heard. He briefly told Melcher of the group's concerns and read the petition. Melcher appeared to be growing tired, when another woman from the group opted for action. She grabbed the petition as Banderob started to sit down, pushed a pen at Melcher and told him that the group would like him to sign it. With a blush and a smile he complied. She then took it to Mrs. Melcher. The meeting want on to other topics.

[FROM THE MONTANA STANDARD, FEB. 25, 1982]

BUTTE SENIOR CITIZENS JOIN LOBBY AGAINST BENEFIT CUTS

(By Jim Tracy)

They don't act like people who would sit timidly by in the face of a challenge. There's vigor in their voices and fire in their eyes.

When 200 senior citizens from Butte and surrounding communities got together Wednesday in the Miners Union Hall, they seemed prepared to fight proposed cuts in medicare and medicaid, to push for national health insurance and to vote out of office those who would take away benefits they have earned.

Most of them signed a petition—and took copies to pass around—that urge citizens "to call a halt to discriminatory (budget) cuts."

Wednesday's gathering was billed as a forum to answer questions about proposed cuts in medical benefits for the elderly.

According to the National Council of Senior Citizens in Washington, D.C., the cuts would include:

Charging medicare patients 10 percent or up to $26 a day for the second to 60th days of hospital stays. Under present law, medicare patients make a first-day payment of $260, then are fully covered for days two through 60.

Making employers continue private health insurance coverage for those who continue to work after age 65. Medicare coverage no longer automatically goes into effect at age 65 for most workers.

Permitting the states to charge low-income medicaid patients for a small part of basic health care services, such as a few dollars a day for hospital stays and visits to a doctor.

Reducing Federal reimbursements to hospitals for treatment of medicare patients by 2 percent across the board. The administration says the proposal will save $600–$800 million.

Allowing States to require families of medicaid patients in nursing homes to supplement Government payments for nursing home bills. The plan could result in garnishment of patients' property.

Reducing by 3-percent Federal reimbursements to States for costs of optional services provided under medicaid.

Limiting medicare payments to radiologists and pathologists to 80 percent of normal charges; eliminating medicare subsidies for private hospital rooms; and instituting a program to reduce medicare hospital stays.

Many of those who sat in the Miners Union Hall Wednesday view those and other proposals as "a kick in the pants to those who have worked hard all their lives to keep America going," as one woman put it.

Retired railroad man Tom Brophy views them as an insult, and he doesn't take insults lightly.

"We older Americans have very strong leverage," Brophy said. "There's no reason for us to be timid. We must flood Washington with protests and tell our Congressmen, 'It's you who make the law, not Ronald Reagan or David Stockman.'"

"We're asking for a Government that cares—cares about us here," he said. "We do believe in fiscal responsibility, but not at the expense of the elderly."

His comments were met with loud applause.

If the proposals go through, "The elderly won't be able to afford to go to a doctor," said Sonny Powers of Whitehall, forum moderator. "We've got to get together and fight this thing through.

Others proposed more radical solutions.

"Why don't we get social medicine?" asked retired miner Bernard Henderson. "Why not aim higher? We're the only country that has this stupid medicare."

Henderson said he believes much of the blame for high medical costs lies with doctors and hospitals.

"Did Reagan ever say anything about cutting doctors' pay—or how much they make?" he asied. His remarks also were greeted with loud applause.

Powers suggested that the elderly, including some 115,000 in Montana, build "a stronger lobby" than the American Medical Association.

He remarked that doctors "take you in for 10 minutes, look you over and kick you out at a cost of $45."

"Oh No!" came a voice from the audience. "A hundred dollars." Still another said, "No, it's $150."

Others talked about scrapping the proposed MX missile and limiting foreign aid as a means of retaining current benefits for the elderly.

What will come out of the forum is still to be seen. But those who attended agreed to meet again March 24 to talk about the success of their petition and how they may work more closely together.

Brophy ended the meeting with a quote from Martin Luther King: "We shall overcome."

[From the Independent Record, Mar. 3, 1982]

SENIORS SHOW INDIGNATION OVER CUTS

(By Pat Murdo)

Those with questions and those with gripes about President Reagan's proposals for medicare, medicaid, and social security gathered Tuesday in Helena in part of a statewide attempt to energize "gray power."

About 75 people attended an informational and organizational meeting sponsored by the Montana Senior Citizens Association to petition the administration to forget proposed cuts in services to the elderly and to restore budgets that already have been cut.

The curious sat beside the indignant: "I thought the president was supposed to take care of medicare and medicaid" (under a proposal by the Federal Government to exchange State medicaid programs with Federal aid to families with dependent children). Her neighbor retorted: "He (Reagan) is taking care of himself."

Fears about cuts in medicare and social security mingled with anger about proposals to combine the Railroad Retirement fund and social security.

Railroad employees have paid into a separate fund that was matched on their retirement by the railroads; the fund is considered healthier than social security.

Bob Virtz, who retired from the railroad in January, told the crowd that the railroad pension was supposedly secure until the end of the century under legislation passed last October.

"The ink hadn't dried before they were trying to whittle it (the pension fund) down." Virtz said. "Boy we'd better get on the ball."

The only applause during the meeting came in response to an indignant mother's reaction to proposed cuts in veteran's disability medical care, to which her son is entitled.

"If they take anything out of Clifford's small medical payment, I think Reagan should be spanked with a brush on his bare butt," fumed Hazel Houston.

Another senior citizen ranted about the increases of 200-300 percent in medical costs in the past 4 years and an inflation rate that last month dropped only .3 of 1 percent.

Elton Barnes blasted a system that required his hospitalization for 18 hours against his will, for which all but $205 of the final bill was covered by insurance. But that $205 had to be paid from a $215 a month pension.

"How much persecution are we senior citizens to take, financially?" Barnes asked.

Reagan's policies weren't the only ones targeted for senior citizens' ire.

H. H. Gullickson criticized Governor Ted Schwinden for signing a bill that counted railroad retirement and veterans' disability pay as income when considering homeowners' tax credits.

Renee Brereton of the senior citizens' association said the group would be meeting with a legislative committee next month to discuss the problem that arose after passage of House bill 337.

Other than a few heated attempts to urge seniors to write to their Congressmen, Reagan and Richard Schweiker, director of the Department of Health and Human Services, most of the meeting was low-key.

Seniors took copies of petitions home with them after Brereton and emcee Tom Ryan urged them to bring in the signed petitions on an April 30, National Medicare Alert Day.

The meeting was the seventh in a month-long, statewide campaign to organize seniors to campaign against proposed medicare/medicaid policies.

AFL-CIO SUPPORTING SENIOR MOVE

A statewide labor organization Tuesday pledged to join with the Montana Senior Citizens Association in fighting further Reagan administration cuts in medicare.

"The Reagan administration's attack on this Nation's elderly is unconscionable," said Jim Murry of the Montana AFL-CIO in a prepared statement.

He said Reagan is requesting almost $3 billion in cuts in the medicare program for fiscal 1983. "As of January 1, 1982, there has already been an increase of over 25 percent in the medicare deductible, and President Reagan's latest proposal would mean that a medicare patient could pay up to $2,500 a year for medical coverage."

Murry, the organization's executive secretary, said he would ask all affiliated unions to join in a letter writing campaign to Montana's congressional delegation.

SENIORS WELCOME LABOR'S SUPPORT ON MEDICARE

(By IR State Bureau)

The Montana Senior Citizens Association says it's happy to have the Montana AFL-CIO as an ally in its fight to save medicare from further Reagan administration budget cuts.

"The State and national AFL-CIO have a long and proud tradition of acting as a 'peoples lobby' and they have always been in the forefront of the battles for social justice and equality," said Tom Ryan, the association's legislative coordinator.

Montana senior citizens recently decided to launch a petition drive protesting medicare and medicaid and asking Congress to begin restoring "buying power and equality to the American people." They also are making plans to participate in a national senior citizens protest April 30.

Ryan said the association will ask organization labor to help with the petition drive and join the demonstration. He also warned that the administration's policies will concentrate wealth in the hands of a few at the expense of the ordinary citizen.

"Senior citizens remember only too well the hard times of the 1930s," he said. "We remember the desperation of workers without jobs, the breadlines of the hungry, the sick who could not afford health care. We are determined that those times will not come again and we will not stand still while the Reagan administration works to dismantle those programs designed to prevent such a depression ever again occuring in our country."

STATEMENT OF THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

Mr. Chairman, The National Association of Private Psychiatric Hospital appreciates this opportunity to react to the fiscal 1983 medicare budget cuts proposed by the administration. We have serious reservations about unilateral actions taken without the benefit of a long-term approach to restructuring a total system. We feel many of the proposed reductions are short term in nature and will do nothing to control costs over the long haul.

At the outset we must state that we are unalterably opposed to the 2 percent reduction in medicare hospital reimbursement. It would cut payments to hospitals across the board, disregarding their efficiency, costs, case mix, intensity, or occupancy. We oppose cuts which are arbitrary, inequitable, and do nothing to resolve the real problems facing the medicare program. Furthermore, such a cut would penalize those hospitals serving a higher proportion of medicare beneficiaries. This seems totally punitive towards those hospitals committed to serving the medicare population.

The National Association of Private Psychiatric Hospitals represents the Nation's 203 freestanding (nongovernmental) psychiatric hospitals and related hospital-based psychiatric services. The hospitals, with over 24,000 beds, represent a variety of types of ownership and provide for the medical care and treatment of persons suffering from psychiatric disorders and impairments. The membership offers the wide and varied range of competitive hospital-based programs critical to addressing the needs of children, adolesents, adults, the elderly, the alcoholic, and the substance abuser. All of our member hospitals are accredited by the Joint Commission on Accreditation of Hospitals, the national agency for voluntary accreditation of hospitals.

We would like to take the opportunity to comment on some of the proposals mentioned in the administration's budget recommendations, as well as comment on some proposals not yet introduced but under active consideration by the administration.

SPECIFIC PROPOSALS

REPEAL WAIVER OF PROVIDER LIABILITY

This provision would repeal a prior amendment passed by Congress to protect both institutions and beneficiaries from a retrospective denial of reimbursement for services. We believe this provision would unjustifiably penalize institutional providers which have delivered care deemed medically necessary and appropriate on the orders of physicians and other health professionals. Since physicians, not hospitals, order such services, such a repeal under part A would be unfair.

ELIMINATION OF UTILIZATION REVIEW REQUIREMENT/HCFA/PRIVATE SECTOR UTILIZATION REVIEW INITIATIVE

While agreeing in concept to the elimination of burdensome regulatory activities for hospitals, we are concerned that this proposal, established to save in excess of $300 million, has not yet been fully developed or articulated. We would and do strongly object to returning to a system which would vest the intermediary and third party payor with the responsibilities of reviewing care or determining the criteria under which care is deemed medically necessary or appropriate. Such a system would revive the arbitrary and capricious retrospective denials of care, which the psychiatric hospital is all too familiar with.

This association has endorsed the elimination of the PSRO program and is committed to developing a system which will remain institution specific in allowing the individual hospital utilization review committees to develop norms for admissions, lengths of stay, discharge criteria, et al. Such a system would allow each institution to develop norms applicable to its setting, treatment goals, treatment objectives, and unique capabilities. Any system developed only with the payor's interest in mind would be unfair and in the long run more costly to a system, only encouraging inappropriate utilization or under utilization.

MEDICARE CONTRACTOR INITIATIVE

This proposal would eliminate the provider's ability to nominate their own intermediary. Presently, the Secretary is required to assign intermediaries based on published standards and criteria for efficient administration. The proposed amendment would remove such a requirement. We feel such a proposal would be a detriment to the system.

OTHER PROPOSALS

EXPANDING SECTION 223 LIMITATIONS

While this proposal has not been formally introduced as part of the fiscal year 1983 budget, the Department continues to give active consideration to lowering section 223 limits and expanding them to ancillary services. The specialty psychiatric hospital has long had difficulty in being reimbursed for what has been considered routine for their programs. The true cost of providing medically necessary psychiatric care must include therapeutic services, that is, education, social services, and therapeutic modalities. Such services are required of specialty hospitals under the conditions of participation for the medicare program. However, they are rarely reimbursed. A further tampering with the section 223 limitations would seriously limit the speciality hospital's ability to be adequately reimbursed and most likely would result in the hospital's inability to continue to adequately treat the medicare population.

PROSPECTIVE REIMBURSEMENT SYSTEM

This association stands ready to assist the committee and other interested parties as they explore alternatives to the present cost based, retrospective reimbursement system.

Such a system, however, must not penalize hospitals and must allow for such factors as intensity, case mix, efficiency, labor costs, debt financing, inflation, and demand.

The association believes that the health care system has moved in the direction of greater competition and encourages this movement. While increased competition in the health care system may slow down escalating costs, any "procompetitive" approach should be implemented with thoughtful regulation in order to assure that consumers have adequate information about competing health plans and to protect unsuspecting consumers from plans which exclude necessary services.

Competition among health plans must be based on differences in deductibles, copayments, catastrophic stop-loss contributions, and supplemental services. In addition, a basic package of minimum benefits must be maintained for all qualified competition health plans. Such a package should include all medically necessary physician and hospital services with no distinctions made between any medical specialties.

In conclusion, we believe a framework is crucial to assure adequate and continued reimbursement for all appropriate costs attributable to the medicare program designed with incentives for the long-term solvency of the program, minimizing cost shifting, assuring a catastrophic element not now found within the program, beneficiary cost sharing, and allowing for adequate planning to meet increasing demands.

Mr. Chairman, we thank you and the subcommittee for giving us the opportunity to comment and we look forward to working with you as you consider the above proposals.

STATEMENT BY THE U.S. CONFERENCE OF MAYORS AND THE U.S. CONFERENCE OF CITY HEALTH OFFICERS

The U.S. Conference of Mayors is pleased to have this opportunity to comment on proposed changes in the medicare program.

It is the position of this organization that provision of medical care to those in need is the direct responsibility of the Federal Government. For this reason, we have supported the medicare program, federalization of medicaid, and the national health insurance concept. Also, for this reason, we are troubled by certain legislative changes in the medicare program the administration would initiate in fiscal year 1983.

The Conference of Mayors recognizes this is a difficult time and a need exists to find ways of cutting the Federal Government's costs. This should not occur at the expense of the elderly or of local governments that have traditionally served this population.

Medicare eligibles—the middle class elderly included—live on fixed incomes at a time when inflation continues to rise and their personal health status is demanding more, not less medical attention. The situation in itself represents a hardship for many. Significant numbers of elderly cannot bear additional health costs without sacrificing other essentials such as food, shelter or energy.

Local governments, facing reductions in revenue and forced, by law, to maintain balanced budgets, already show shortfalls in almost all public service areas. The imposition of still greater financial responsibility for health services is not acceptable to the Nation's mayors.

Of the proposed changes, three are particularly disturbing:

Two-percent reduction in hospital reimbursement. A cut below current rules would result in a shifting of cost to the elderly and local governments. Some elderly would, of course, continue to receive care from voluntary and private hospitals. Others would be shifted, or dumped, onto public hospitals. Those dumped on public hospitals would represent an addition to the already large group of patients for whom public hospitals are the providers of last resort. Many of these patients currently result in bad debts. The administration's plan would have this population, plus new medicare patients, reimbursed at a loss of two percent; effectively creating a double burden for local governments.

We assume that hospitals which continue to serve medicare patients while absorbing a 2-percent reduction would demonstrate comparable price increases in other billing areas. Thus, the Federal Government will save money at the expense of hospitals, patients, and insurers.

Changes in health benefits for the working aged. Requiring employers to offer workers age 65-69 the same benefits as younger employes presents potential for discrimination against the elderly. In addition, in the case of elderly workers employed by municipal governments, this practice would shift costs of health coverage from the Federal Government to local governments.

Delay of physician fee schedule updates. By postponing until October the update of physician fee schedules and cutting this year's increase by 3 percent, medicare patients would be less attractive clients in the eyes of private medical practitioners. This is likely to result in discrimination against medicare patients, which in turn will result in a limiting of consumer choice in local governments' being forced to provide more services through public hospitals and outpatient facilities.

RECOMMENDATIONS TO ACHIEVE REQUIRED CUTS IN THE FISCAL YEAR 1983 MEDICARE BUDGET

TUESDAY, JUNE 15, 1982

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met at 10:30 a.m., pursuant to notice, in room 1100, Longworth House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

[Press release announcing hearing follows:]

[Press release of Tuesday, June 8, 1982]

Hon. Andy Jacobs, Jr., Democrat of Indiana, Chairman, Subcommittee on Health of the Committee on Ways and Means, Announces Hearing on Proposed Budget Cuts Affecting the Medicare Program To Be Held on June 15, 1982

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a public hearing on Tuesday, June 15, 1982, on recommendations for legislation to achieve required cuts in the fiscal year 1983 budget for the medicare program. The hearing will be held in Room 1100, Longworth House Office Building, beginning at 10:00 a.m.

At this time, the Subcommittee does not know the magnitude of the spending reductions in the medicare program that will be required for the forthcoming fiscal year. On March 2, 1982, the Subcommittee held a day of hearings on the Administration's proposals for medicare budget cuts of about $2.5 billion. Proposals recently considered in the House of Representatives called for medicare spending reductions ranging from zero to $4.8 billion in fiscal year 1983. Because this broad range of possible budget targets will require the consideration of a variety of proposals to reduce spending, the Subcommittee seeks the advice of witnesses regarding responsible methods for achieving targets within that range.

Chairman Jacobs emphasized that the Subcommittee is primarily seeking advice on budget reductions for fiscal year 1983. However, the Subcommittee will entertain concise testimony on proposals aimed at producing significant and fundamental reform (e.g., certain proposals related to prospective or per captia payment arrangements) resulting in long/range savings to the medicare program.

Due to time restrictions, the hearing will be limited to testimony from the Administration, the Congressional Budget Office, and other invited witnesses. The Subcommittee would, however, welcome written statements form interested organizations and individuals for inclusion in the printed record of the hearing.

PROCEDURE TO BE FOLLOWED FOR SUBMITTING WRITTEN COMMENTS

Interested individuals and organizations may submit written comments, which should address only the above subject, through the close of business, Wednesday, June 30, 1982. Comments, 5 copies should be submitted to John J. Salmon, Chief Counsel, Committee on Ways and Means, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements for the record of the printed hearing wish to have their statements distributed to the press and the interested public, they may submit 50 additional copies for this purpose if provided to the Committee during the course of the public hearing.

Chairman JACOBS. The committee will come to order.

The purpose of this morning's hearing is to determine whether or not the U.S. Government can keep its word to medicare beneficiaries.

I yield to the gentleman from Ohio.

Mr. GRADISON. Mr. Chairman, we have both an important and difficult task before us in this subcommittee in trying to reconcile the medicare program as we have known it with the budget reductions which are likely to be required of us by the conference, which is just getting underway this afternoon.

I want to thank the chairman for holding this hearing, and observe that these people here are a lot of people anxious to help us in running the medicare programs.

It is evident from consideration in both the House and in the other body that savings are indicated and can be achieved.

Both major versions which the House considered, the Jones version, and the Latta version, call for substantial savings in medicare and differ in amount, but as far as the notion of having some savings, they both indicated that savings were desirable and achievable.

Certainly we have got to bear in mind that if we do not take some action, we are headed for a period sometime later this decade when medicare funds are going to be exhausted, and, as a result, it is not a bit too early to start to ask what can be done to prevent that by finding ways to reduce the costs of this program beyond what they otherwise would be.

There were a number of medicare proposals discussed during the House consideration of this matter.

We are not bound by any of the assumptions used at that time, but it is useful to take a look at what the thinking was of those who offered the savings proposal in the House.

The House-approved budget targets the major portion of its savings on providers of services, primarily hospitals and physicians.

There were no assumptions made which would have reduced outlays through indirect beneficiary cost saving.

For the fiscal years 1983–85, savings would total $11½ billion. That amounts to only 5.7 percent of the over-$200 billion in outlays projected under current law over that same 3-year period. Over half the savings, or about $6 billion, were assumed to come from placing a prospective limit on hospital costs under the Medicare programs.

They would represent 4 percent of the projected hospital expenditures of over $135 billion over that 3-year period.

The balance of $11½ billion in outlay reductions, or $5½ billion, was assumed to come from other provider reimbursement reforms and a proposal to make medicare coverage secondary to private group insurance for the working agent.

Depending on what comes out of the conference with the other body, our 3-year target could ultimately be between the $11½ billion House figure and the $18.2 billion figure approved by the Senate.

A compromise will have to be struck somewhere between $3.2 billion and $4.1 billion for the upcoming year.

Needless to say, we have a great opportunity today in hearing from people who studied this for a long time and having the benefit of their recommendations as to how these savings can be achieved, and I am looking forward with keen anticipation, Mr. Chairman, to the comments of our witnesses.

Chairman **Jacobs**. The modest cuts made in the medicare program last year largely accounted for a subsequent 70-percent increase in medigap insurance premium costs in the State of Indiana.

The Chair will further observe that it seems difficult to discuss the advisability of further burdens on the elderly through the medicare program in the context of a budget so bloated with waste, not only in the military area but in many domestic areas as well, and will quote the famous Hoosier philosopher who said, "There is always plenty of money for everything but the necessities."

With that, the Chair will also announce that our first witness today is the Honorable Richard Gephardt, of Missouri, who will, in fact, not be the first witness, but will be listed as the first, and be here later.

The second shall be first, and we are deeply honored to welcome and to learn from our colleague, Mr. Waxman, who chairs the Health and Environment Subcommittee of the Commerce Committee.

STATEMENT OF HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, COMMITTEE ON ENERGY AND COMMERCE

Mr. **Waxman**. Thank you very much.

I am Henry Waxman and not Richard Gephardt.

We are often confused, but he is a much better-looking fellow.

I want to thank you for the opportunity to testify this morning.

Medicare is a national commitment, a promise to 29 million aged and disabled citizens. It is a promise that is already far too limited—medicare already pays less than 45 percent of the health bill of the aged. The Latta budget requires us to break that promise. Despite the rhetoric we heard last week during the budget debate, we must now face the harsh reality of what the House has passed.

To understand that budget, I think it useful to look back 1 month to our first debate on the fiscal year 1983 budget resolution. You undoubtedly recall that there was a broad consensus that deep cuts in medicare were not acceptable, a consensus that went a long way toward defeating that first Latta budget. Thus, the designers of Latta II faced a difficult problem. On the one hand, they wanted to protect last year's tax cut, and their defense spending proposals, and to maintain an acceptable deficit. On the other hand, they faced this consensus against medicare cuts, which put pressure on their tax, defense, and deficit targets.

The solution in Latta II was ingenious—they still made deep budgetary cuts in medicare and other health programs, but managed to obscure those cuts with rhetoric that they were not really cuts, or at least cuts that would hurt anyone. They provided a so-called "restoration" of the medicare cut, but still slashed $3.2 billion from medicare, and financed that "restoration" at the expense of medicaid, which now suffers a further $1.3 billion reduction. But their rhetoric was reassuring and positive, and the budget passed.

Let me briefly review some of those assurances given to the House of Representatives before the vote.

The sponsor of the amendment, Mr. Latta, in discussing medicare reductions, said that "* * * they will not be affecting the individual recipients. So, cutting is the wrong word to use."

A member of this committee, Mr. Martin, assured us that "the proposal we have does not require any medicare cuts for individuals."

The ranking minority member of this committee, Mr. Conable, provided a list of proposals included in the plan that assured us that "No assumptions are being made to reduce outlays through direct increases in beneficiary cost sharing."

However, the ranking minority member of my subcommittee, Mr. Madigan, acknowledged two such increases in cost sharing—an increase in the part B deductible, and the imposition of cost sharing on home health services.

At the same time, documents were circulating on the floor titled "Setting The Record Straight" and assuring Members in bold, underlined type "Medicare: No Increase in Out of Pocket Costs." The rhetoric was not limited to medicare. Medicaid, cut by $1.3 billion, including more than $1 billion in direct Federal matching reductions which simply shift costs to States, was the subject of equally compelling rhetoric in this document, for we see, again in bold, underlined type: "Medicaid: No New Burden Shifting to States."

Mr. Chairman, as you well know, the problem that we confront is that these positive statements are not matched by the proposals under discussion. That fact will become all too clear as we proceed to develop legislation to meet these savings targets. Let's look at some of the specific proposals that appear to be included in this Latta alternative, to see how they would shift costs.

First, despite all of their rhetoric to the contrary, Latta includes two proposals that would directly shift costs by increasing cost sharing. They would increase the part B deductible by indexing it to the CPI, and they would impose cost sharing on home health services. These two proposals would directly increase out-of-pocket payments by the aged and disabled.

Second, Latta includes the working aged proposal, requiring employers to continue private health insurance coverage for aged individuals who keep working beyond their 65th birthday. This proposal simply shifts medicare costs to those private health insurance plans and their premium payors. The result is potential discrimination against elderly individuals seeking to remain employed, because of their higher health risk and cost. In addition to the working aged proposal, Latta would tamper with entitlement in another way—eligibility would be delayed to the month following the month in which the individual attains age 65. This simply shifts costs again—to the individual beneficiary, or to their health plans for those who are insured.

Third, Latta includes cuts in physician reimbursement that would inevitably shift costs to beneficiaries. These proposals include an arbitrary 3-month delay in updating fee screens, and an equally arbitrary 5 percent cap on the rate of increase in prevailing fees. The rhetoric on the floor of the House was that these proposals affect only the highly-paid physician. The reality once again is bad news for the beneficiary, for these "savings"—from what we are not going to pay for physicians—can be passed on to the patient. As this committee knows, physicians have an option of accepting assignment under medicare. If they accept assignment, they accept medicare's definition of reasonable charges as payment in full. However, if they do not accept assignment on a bill, they can bill the patient for charges over and above the amount medicare defines as reasonable. Currently, about one-half of physicians' bills are not assigned, so the patients are billed for an additional amount over and above what medicare pays. The cuts proposed in Latta will simply exacerbate the assignment problem, and result in more costs being shifted to these patients. Again, these are increases in out-of-pocket payments by the beneficiaries.

Finally, Latta includes hospital reimbursement reforms saving roughly $660 million in fiscal year 1983, plus another $150 million in hospital reimbursement reductions through elimination of the private room subsidy and the nursing differential. I have long advocated reforms to move us to a more prospective payment system under medicare, and we could start with a total cost target for each hospital based on the patient mix that they serve. While the proposals under discussion deal with medicare payments only, such a system should provide encouragement to States to develop across-the-board rate-setting programs, and allow medicare participation in those programs if they can meet standards of equity and cost control. In addition, some limitations on capital spending should be included to discourage unneeded beds.

However, as we proceed with these hospital reimbursement proposals, we should all recognize some difficult problems that have to be addressed. Since we are dealing with medicare only, we must be sensitive to cutting into medicare payments so deeply that the program becomes a less and less competitive purchaser of care. The result of such a policy would be to further shift costs to other payors in the short term, and to reduce the medicare beneficiaries access to care in the long term. That result is simply unacceptable. Second, I would caution the Members to guard against proposals that limit medicare's payment, but leave the beneficiary responsible for additional amounts if the hospital chooses to pass along the costs or charges. With very limited exceptions, medicare payments to hospitals are designed to be payment in full. We should not alter that vitally important feature of the program and protection for the beneficiary by moving to a hospital reimbursement system that results in such costs being passed on to the elderly and disabled. Finally, if we are unable to reach the preliminary savings targets, we must make sure that we do not make up for the shortfall with other proposals that would shift more costs to the patients.

Mr. Chairman, that concludes what we know about the Latta budget. Almost every one of their proposals except hospital reimbursement can shift costs directly or indirectly to the beneficiaries. Even the hospital reimbursement savings would shift costs to other payors, and runs the risk of forcing us to design a plan that would increase beneficiary payments.

The rhetoric we heard on the floor of the House stressed that Latta two would not affect the aged and disabled beneficiaries. I personally do not know of any way to make this deep, $3.2 billion cut in medicare in the next 3 months without hurting the beneficiary, any more than I know how to make a $1.3 billion cut in medicaid without hurting the States or medicaid beneficiaries. It is apparent that the developers of Latta do not yet know how to accomplish that objective, either. If we can develop some proposals that achieve positive reforms and do not hurt the beneficiaries, fine. If the administration wants to push for enactment of all their current proposals despite the fact that they do hurt the beneficiary, that option is, of course, available to them. But make it available to them on the floor. Let us not contribute to their shifting the cost to the beneficiary, putting to a lie the statement that they made at the time to Members of the House and to the public that they made during that debate.

In this committee, use as your guide the principle that no cuts will be made at the expense of the aged and disabled people this program was designed to serve. Don't ask them to pay directly out of pocket. Don't ask them to pay indirectly by making cuts we all know will be immediately passed on to them. I look forward to working with you to preserve these programs that protect our Nation's most vulnerable citizens.

Chairman JACOBS. Mr. Rangel will inquire.

Mr. RANGEL. Thank you, Mr. Chairman.

I am thoroughly convinced that the administration believes that Government is too involved in any type of services as relates to the sick and the poor. I had the Secretary of Housing and Urban Development come into my district and tell the people that were interested in housing that they should wait for the enterprise zones to come, because that is going to bring housing for the poor, and so following that line of thinking, I would suspect that this administration would be saying that the competition health bill will be providing better care for the Nation's sick.

Have you heard where this—Mr. Gephardt is not here, but he is not the administration, either—but where is the administration's competition health bill? Is it ever going to reach the Hill?

Mr. WAXMAN. We heard so much about the administration's new proposals for competition, and we have been looking forward to seeing the details of that legislation, but they have not been submitted to us.

What we have instead is a short timeframe to make budget accommodations to meet the numbers in order to show that we are cutting Federal expenditures. But that is not going to lead to more competition, and the people will not be able to buy health coverage because they are unable to work.

We see no proposal at all.

Mr. RANGEL. As the tax-writing committee, we will have the jurisdiction to deny tax exemption to employers who want to have enlarged health plans, and we are penalizing them if the plan is too broad, because too many services will be given by restricting this.

In any event, we know that hard times are ahead, and I think the Nation is much better off in having you to chair one of the key committees as we monitor this.

I would be working very closely with the members of this committee, and indeed the House that voted for Latta, because the Republicans have a unique way of having cost savings that are not supposed to affect the people, and I guess a lot of it will come up after the election, but this $40 billion in social security cuts, that is not going to hurt the beneficiaries.

The cuts under the Latta bill supported by the Republicans are not going to hurt the sick; so it is going to be interesting how they are going to do this, but as long as I know that your committee and this committee will be watching it very carefully, I do hope we can get out the releases when we find that there is some bloodletting being done.

Thank you so much for your testimony.

Mr. **Waxman**. Mr. Rangel, I think it would be good for us to look at trying to bring about more competition in the health care sector, but any proposal that has been talked about would have no impact on savings for another 5 to 10 years down the road. What we are being asked to do in the short term is to make cuts in the programs for the beneficiaries, the aged, disabled, and the poor under medicare and medicaid.

We hear their proposal about a new federalism, a Federal takeover of medicaid—that is what they are saying, on the one hand—while and their budget proposals are asking us to shift additional costs to the States.

Mr. **Rangel**. If you penalize the sick, they won't get ill as often. You don't understand that thinking, but they will explain it to you.

Chairman **Jacobs**. Mr. Gradison.

Mr. **Gradison**. Mr. Chairman, I guess it is necessary to indulge in partisan rhetoric to match partisan rhetoric, but I wish we could avoid it this morning. The House of Representatives is not controlled by the Republican Party. It is true that the Latta provisions were developed by Republicans, but it would not have been passed had there not been a very large number of Democrats supporting it, and, therefore, we face the requirement, if we carry out our obligations with the Budget Act reconciliation practice, of coming up to specific numbers to implement these plans.

If you want to lay it on the Republicans, that is fine, but keep in mind you are bringing along a number of 50 or 60 Democrats who also supported this Latta budget.

Mr. **Rangel**. I have taken their names, too.

Mr. **Gradison**. It is important to do so. The vote taken in the House was reflective of a nationwide concern, one which cuts across partisan lines.

Chairman **Jacobs**. I think it is appropriate now to quote the great Hoosier, Charles Halleck, who once said, "I am the minority leader and the leader of the majority."

Today, we are only bugged by the boll weevils.

Mr. **Gradison**. I am not a boll weevil, gypsy moth, or yellow jacket, and I feel left out much of the time, but it would be useful to bring us back to the purpose of this hearing, which is to try to figure out how to achieve these savings.

The gentleman from California, in the statement, in at least three instances, included as if they were part of the Latta recommendation, items which are not—specifically, the increase in the deductible, the cost share for home health services and the 1-month delay.

I would like to ask unanimous consent to insert in the record at this point pages H3381 and H3382 of the Congressional Record of June 10, 1982, specifically a statement by the gentleman from New York, the ranking member of the Ways and Means Committee, Mr. Conable, which does list the items which total up to the savings which were included in Latta II.

They include several of the items that the gentleman from California mentioned, but they do not include the three which I just mentioned, and it is important to do this, to keep the record straight.

I would ask unanimous consent that be included in the record.

Chairman Jacobs. Without objection, it may be included.

[The information follows:]

Mr. Conable. Mr. Chairman, I would like to offer at this point in the Record some commentary on the medicare cuts that the chairman expressed uncertainty about. He was unable to yield me any time but I would like to have appear in the Record some discussion of the nature of the cutbacks and how they could be financed.

The commentary follows:

The Latta Bipartisan Compromise Budget targets the major portion of its savings on providers of services, primarily hospitals and physicians. No assumptions are being made to reduce outlays through direct increases in beneficiary cost sharing.

Medicare savings under the Latta Compromise Budget for fiscal year 1983-85 total $11.5 billion, about one-half of the previous Latta proposal. The savings represent 5.7 percent of the $200.3 billion in outlays projected under current law over the next three fiscal years.

Over half of the savings under the Bipartisan Compromise Budget would come from placing some prospective limit on runaway hospital costs under the Medicare program. The House Budget Committee also listed reforms to limit hospital reimbursement as a source of savings. Although no dollar amount is specified in the Budget Committee proposal, the Bipartisan Compromise Budget calls for about $6 billion in savings (about 4 percent) from projected medicare hospital expenditures of $135.2 billion during fiscal year 1983-85.

The balance of the $11.5 billion in outlay reductions under the Latta compromise Budget ($5.5 billion) could come from other provider reimbursement reforms and a proposal to make Medicare coverage secondary to private group insurance for the working aged.

The following sources of saving could be used to make up the approximately $5.5 billion in additional reductions over the three year period, fiscal years 1983-85.

Eliminate the private room subsidy, $209 million.—Presently, Medicare pays hospitals the excess cost for private rooms—an unintended byproduct of current Medicare cost calculation methods. This proposal would remove the excess cost of private rooms prior to calculation of Medicare's share of total costs. Thus the Federal Government would pay its equitable share of the services provided to Medicare patients.

Reduce unnecessary use of hospital and medical care, $580 million.—The current length of stay of Medicare patients is 11 days on the average. On a nationwide basis, wide variations in the average length of stay indicate that some of these 11 days are unnecessary. This proposal would establish objectives for Medicare contractor activities in cooperation with private sector efforts to reduce unnecessary days and other services. In addition, current provisions that waive provider liability for the cost of unnecessary of uncovered care would be eliminated.

Reduce skilled nursing facility medicare reimbursement to the medical rate, $37 million.—In some States, the Medicaid program pays for SNF care on a different basis than Medicare. This proposal would assure that the Medicare program benefits from economies achieved from Medicaid.

Eliminate radiologist/pathologist percentage contracts, $220 million.- This proposal would eliminate current payments for specialists' services which are reimbursed on a percentage basis from gross revenue for laboratory and X-ray services.

Present compensation is not commensurate with actual services performed. This reform would bring these reimbursement practices into conformance with prevailing practices.

Eliminate double overhead payments for teaching hospital physicians, $280 million.—At present, physicians practicing in teaching hospitals are directly reimbursed for overhead. The teaching hospital itself is also reimbursed for this cost center.

Delay physician fee screen update, $675 million.—The annual physician "fee screen" for charge increases would be put back three months to conform with the Federal fiscal year.

Cap physician fee screen annual increase $135 million.—The physician fee screen annual increase would be limited to a 5 percent increase in the maximum reimbursable fee.

Reduce duplicate compensation for physician care in hospital outpatient departments, $655 million.—This proposal would eliminate the double payment currently made to physicians who practice in hospital outpatient departments. At present, the overhead costs of such care are reimbursed twice—once to the hospital and once through the physician charge payment.

Reduce excessive provider reimbursement, $605 million.—Radiologists and pathologists would be reimbursed at the prevailing rate for all other physicians—80 percent, rather than the current 100 percent paid to these two specialties.

Make medicare coverage secondary to private group insurance for the working aged, $2.1 billion.—Current law provides that all employers who offer health benefit plans may provide employees over age 65 with group health plans that carve out benefits covered by Medicare. This proposal would require employers to offer employees age 65 through 69 the same private health benefits plans offered to younger employees. An estimated 625,000 Medicare beneficiaries (85 percent of the working aged) would be affected by this program. The program would not be a disincentive for hiring the aged as acceptance of private insurance by the aged employee would be optional.

[The following letter was subsequently received from Mr. Waxman:]

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE COMMITTEE ON ENERGY AND COMMERCE,
Washington, D.C., June 17, 1982.

Hon. ANDREW JACOBS, Jr.,
Chairman, Subcommittee on Health,
House Committee on Ways and Means, Washington, D.C.

DEAR MR. CHAIRMAN: At your hearing June 15 on "Proposed Budget Cuts Affecting the Medicare Program," questions arose as to what proposals are included in the Latta Medicare cuts. I would appreciate it if this letter and enclosure would be included as part of the hearings record at that point.

As I said in my prepared statement, and as Mr. Gradison pointed out at the hearing, Mr. Conable provided on the floor a list of proposals that assured us that "No assumptions are being made to reduce outlays through direct increases in beneficiary cost sharing" (Congressional Record, June 10, 1982, pp. H 3381-H 3382).

However, as my prepared statement also pointed out, Mr. Madigan, the ranking minority Member of my Subcommittee, acknowledged some increased cost sharing under the Latta bill—an increase in the Part B Deductible, and the imposition of cost sharing on home health services. His remarks defending this cost sharing are are follows:

* * * With regard to the highest annual deductibles for Part (B) which he says is contained in Latta II and which he represents as being such an extreme hardship on the elderly in this country, the actu(a)rials in the Health Care Financing Administration tell us that if Latta II were adopted and if hospital costs were to continue inflating at the same exorbitant rate as has been the case in the past ten years, that what we would be talking about would be a $5—a $5 obligation for the elderly, an increase in their co-payment from $75 to $80, if health care costs continue to inflate as they have been.

With regard to the allegation that there would be some increase in the coinsurance provisions for home health care, there is no coinsurance provision at all now, so it would not be increased, but we would require the implementation of a 5-percent coinsurance factor for the first time, bearing in mind that home health care is the only item under (M)edicare which does not have some percentage contribution required now, and the others range as high as 20 percent. Here we are talking about only 5 percent for home health care. (Congressional Record, June 10, 1982, pp. H 3349-H 3350).

In addition, I have enclosed for the record a description of the Medicare amendments distributed by the minority staff that includes these cost sharing proposals as part of the Latta package.

I do not intend to defend the extraordinary uncertainty and lack of accountability for what is in this budget. That confusion, in fact, highlights the argument many of us have made again and again—that this Administration asks us to approve multibillion dollar reductions in programs without even the sponsors of their proposals agreeing on what is included in those cuts.

We cannot continue to operate with that lack of accountability and we should not develop Medicare proposals that "save" Federal money in a manner that shifts costs to beneficiaries.

Sincerely,

HENRY A. WAXMAN,
Chairman, Subcommittee on
Health and the Environment.

Enclosure.

MEDICARE SAVINGS PACKAGE

Reform hospital reimbursement.—Under Section 223 of the 1972 Social Security Amendments, HCFA was given the authority to set limits on the amount of Medicare hospital reimbursements by comparing the costs of similar hospitals and disallowing unreasonably excessive costs. Currently under Section 223 authority, HCFA only sets limits for hospitals' routine costs per day (routine costs include room, board, and nursing costs). Since October 1981, limits have been set at 108 percent of the mean cost per day for routine services in comparable hospitals. Since the current limits apply only to a portion of total hospital costs, hospitals are able to shift their costs to the service centers which are not controlled. In the past several years, ancillary costs, which have not been controlled, have increased more rapidly than routine costs. Also, with the current limits set on a per diem basis, hospitals have little incentive to reduce the number of patient days per admission. Another reimbursement reform involves replacing the existing retrospective cost-based reimbursement system with a prospective budgeting mechanism to commence with fiscal year 1984. A number of specific program options exist within the context of this approach, but all share the common theme of prospectively set reimbursement levels. Potential savings from these reforms could total $660 million in fiscal year 1983.

Eliminate the private room subsidy.—Presently, Medicare pays hospitals the excess cost for private rooms—an unintended byproduct of current Medicare cost calculation methods. This proposal would remove the excess cost of private rooms prior to calculation of Medicare's share of total costs. Thus the Federal government would pay its equitable share of the services provided to Medicare patients. This change could save at least $54 million in fiscal year 1983.

Reduce unnecessary use of hospital and medical care.—The current length of stay of Medicare patients is 11 days on the average. On a nationwide basis, wide variations in the average length of stay indicate that some of these 11 days are unnecessary. This proposal would establish objectives for Medicare contractor activities in cooperation with private sector efforts to reduce unnecessary days and other services. In addition, current provisions that waive provider liability for the cost of unnecessary or uncovered care would be eliminated. This proposal could save $165 million in fiscal year 1983.

Reduce skilled nursing facility medicare reimbursement to the medicaid rate.—In some States, the Medicaid program pays for SNF care on a different basis than Medicare. This proposal would assure that the Medicare program benefits from economies achieved from Medicaid. This proposal could save $10 million in fiscal year 1983.

Eliminate radiologist/pathologist percentage contracts.—This proposal would eliminate current payments for specialists' services which are reimbursed on a percentage basis from gross revenue for laboratory and X-ray services. Present compensation is not commensurate with actual services performed. This reform would bring these reimbursement practices into conformance with prevailing practices. Savings could total $63 million in fiscal year 1983.

Eliminate double overhead payments for teaching hospital physicians.—At present, physicians practicing in teaching hospitals are directly reimbursed for overhead. The teaching hospital itself is also reimbursed for this cost center. Elimination of this duplicate payment could save $65 million in fiscal year 1983.

Delay physician fee screen update.—The annual physician "fee screen" for charge increases would be put back three months to conform with the Federal fiscal year. Savings could total $220 million in fiscal year 1983.

Cap physician fee screen annual increase.—The physician fee screen annual increase would be limited to a 5 percent increase in the maximum reimbursable fee. Savings of $25 million could be realized in fiscal year 1983.

Reduce duplicate compensation for physician care in hospital outpatient departments.—This proposal would eliminate the double payment currently made to physicians who practice in hospital outpatient departments. At present, the overhead costs of such care are reimbursed twice—once to the hospital and once through the physician charge payment. This could save at least $160 million in fiscal year 1983.

Reduce excessive provider reimbursement.—Radiologists and pathologists would be reimbursed at the prevailing rate for all other physicians—80 percent, rather than the current 100 percent paid to these two specialties. This proposal could save $145 million in fiscal year 1983.

Eliminate the nursing differential.—The 4.5 percent nursing differential accounts for $95 million in Medicare outlays. Arguments presented during the 1981 Budget Reconciliation debate (during which the differential was reduced from 8 percent) are persuasive that this subsidy is no longer needed.

Extend the hospital insurance tax to cover Federal employees.—At present, federal employees do not pay FICA taxes. By proportionally extending FICA coverage for HI costs to federal workers, the HI trust fund would be increased by approximately $619 million in fiscal year 1983.

Make medicare coverage secondary to private group insurance for the working aged.—Current law provides that all employers who offer health benefit plans may provide employees over age 65 with group health plans that carve out benefits covered by Medicare. This proposal would require employers to offer employees age 65 through 69 the same private health benefits plans offered to younger employees. An estimated 625,000 Medicare beneficiaries (85 percent of the working aged) would be affected by this program. The program would not be a disincentive for hiring the aged as acceptance of private insurance by the aged employee would be optional. It could save at least $610 million in fiscal year 1983.

Index the medicare part B deductible.--This proposal would index the current $75 SMI deductible to keep pace with inflation, thus keeping its real economic value constant. Note that if the SMI deductible had kept pace with inflation since its inception, it would now be over $100. This proposal would raise the deductible approximately $5. It could save $65 million in fiscal year 1983.

Medicare eligibility to commence at the beginning of the first full month after attainment of age 65.—This change would conform Medicare practice to similar changes proposed for other entitlement programs. It could save $145 million in fiscal year 1983. Beneficiary impact would be slight (i.e., would only entail that portion of a month prior to the first full month where beneficiary would be uncovered by Medicare).

Institute copayments for home health services.—At present, home health services are the only benefits which do not require some beneficiary contribution. At a result, the program is growing at an annual rate of 30 percent per year. This proposal contemplates a copayment of 20 percent after the first 20 days of care. (This 20 percent is the same level of copayment as for physician services.) Proposal could save $100 million in fiscal year 1983.

MEDICARE SAVINGS PACKAGE

[In millions]

	Fiscal year—			
	1983	1984	1985	Total
Reform hospital reimbursement	$660	$850	$950	$2,460
Eliminate private room subsidy	54	75	80	209
Reduce unnecessary use	165	195	220	580
Reduce SNF reimbursement	10	12	15	37
Eliminate percent contracts	63	73	84	220
Eliminate teaching physician overhead payments	65	90	125	280
Delay fee screen update	210	235	230	675
Cap fee screen increases	35	45	55	135
Eliminate outpatient physician overhead payment	160	225	270	655
Reform radiologist/pathologist reimbursement	145	210	250	605

MEDICARE SAVINGS PACKAGE—Continued

[In millions]

	Fiscal year—			
	1983	1984	1985	Total
Eliminate 4.5 percent nursing differential	$95	$110	$110	$315
Extend HI tax to Federal employees	619	844	933	2,395
Medicare secondary insurer of working aged	610	700	790	2,100
Index medicare part B deductible	65	145	230	440
First full month eligibility	145	183	217	545
Institute home health copayments	100	165	230	495
Total	3,201	4,157	[1] 4,789	12,147

[1] This out-year figure is significantly greater than the $4,200,000,000 projected in the Latta/Stenholm Package. The $4,789,000,000 shown above is based on actuarial calculations made by HCFA in June 1982.

Chairman JACOBS. I ask unanimous consent to include a letter from the Honorable Fortney Stark, a letter to the committee on this subject at this time.

[The information follows:]

HOUSE OF REPRESENTATIVES,
Washington, D.C., June 15, 1982.

Hon. ANDREW JACOBS, Jr.,
Chairman, Subcomittee on Health,
Committee on Ways and Means, Washington, D.C.

DEAR MR. CHAIRMAN: I wish you luck in your effort to find major cost-savings in the Medicare program. Certainly, some savings can be made and some improvements in administration can be achieved. But I fear that the Latta Budget goes beyond that, and that it may force cuts which will adversely affect the health care of many of our Nation's lowest income and most defenseless citizens.

While I know that your hearing today is designed to find ways to cut costs, I would like to call your attention to legislation introduced by Rep. Oberstar and myself to impose a 10 cents per pack increase in the excise tax on cigarettes, and to divert the $3 billion per year raised by this tax to the Medicare Trust Fund.

The enactment of this bill (H.R. 5333), or any excise tax increase between 1 cent and 10 cent, would go a long ways to help strengthen the Medicare programs and remove the pressures for cuts in benefits to the elderly.

I generally oppose excise taxes, because they are not progressive taxes. But in the case of cigarettes, there is irrefutable scientific evidence that the person who elects to smoke injures his health, and to the extent that that person becomes eligible for Medicare, imposes the cost of treatment on society and the Medicare Trust Funds. It is only fair and just that the smoker contribute to the approximate increased costs of treating smoking-related diseases. It is estimated by various health groups that in 1980, the extra cost of Medicare and Medicaid treatment of smoking-related diseases was about $3.8 billion. (The national productivity cost of smoking has been estimated at more than $25 billion.)

Thus, the health costs of smoking are about the amount of money we are being asked to save in the Medicare fund.

I believe that if you were to put to the House the option to increase excise taxes on cigarettes versus cutting health protection for seniors, the House would embrace the idea of charging more for the right to both smoke and receive Medicare coverage.

I know that an excise tax bill is not within the jurisdiction of the Subcommittee, but I hope that you will include it as an option in your recommendations to the full Committee.

Thank you for your consideration of this idea.

Sincerely,

FORTNEY H. STARK,
Member of Congress.

Mr. GRADISON. I would like to ask Mr. Waxman if he could spell out how he would achieve the $1.4 billion of savings which would be required under his own amendment?

Mr. **Waxman**. I am happy to answer that question. I do want to point out before I answer that question, that the record ought to reflect the comments by Mr. Madigan that, in fact, there will be out-of-pocket costs under the Latta proposal because of the increase in the deductible, and other documents which will be submitted, because we ought to have it very clear to the Congressmen who voted on this proposal what was involved when we were making these Medicare cuts.

I suggest that we make the modest cuts which amount to a significant amount of money that we proposed in the Jones medicare budget. That would have included regulations to change reimbursement for hospital-based physicians, a new utilization control program by the intermediaries and carriers, elimination of the indirect subsidy for private rooms, revised payment for outpatient physicians' services to account for their lower overhead costs, and revised nursing-home and home health cost limits.

These regulatory proposals, which were the administration's regulatory proposals, added to hospital reimbursement reforms, and paying pathologists 80 percent of reasonable charges, would have been the way we could have come up with the savings under the Jones medicare budget.

To those who passed the Latta II proposal, we would like to see how you would accomplish the cuts in medicare of the magnitude in that budget, and still keep the promise of not shifting costs to the beneficiaries. I have not seen a proposal. What we saw did shift cost to the beneficiaries. You now deny that those proposals are in there.

Let's see what is being proposed; if we can keep that promise, of savings of medicare expenditures without shifting the costs to the elderly and the disabled, I would want to work with you.

Mr. **Gradison**. Thank you. May I say, this is encouraging to me in the sense I think there is some common ground here. Can you give me any idea what the total savings would be of the items which you just listed?

Mr. **Waxman**. Fiscal year 1983, we figure $1.4 billion savings, and $2.488 billion in 1984, and $2.886 billion in 1985.

Mr. **Gradison**. $1.8 to go.

Thank you, Mr. Chairman.

Mr. **Rangel**. I thought maybe you would want to take a look at Mr. Latta's statement in the Congressional Record, so that you would have the opportunity to agree with Chairman Waxman, if it is not in the proposal. Mr. Latta thought it was in the proposal.

Mr. **Gradison**. I am aware of the statement that you just called to my attention, and I have been relying in my comments on the statement by Mr. Conable, which I just put in the record. There were differences which I acknowledge in the explanations which were made on the floor, as far as how these savings would be achieved.

My understanding was that, in part—excuse me?

Mr. **Rangel**. It is not called the Conable bill, and he was referring to Mr Latta's bill that passed with the Republican bipartisan bill, so I am not arguing with you. I just thought we should believe what Mr. Latta said was in the bill.

I would like to enter into the record that part of the Congressional Record, May 25, 1982:

> By eliminating reimbursements for uncovered services, by delaying the medicare coverage until the first full month of eligibility, indexing of part B physician coverage deductible to the CPI . . .

That is on page 2766.

If Mr. Waxman is guilty of believing what Mr. Latta said, let the Congressional Record show what he said.

Chairman JACOBS. Without objection, the excerpt from the Record will be included.

[The information follows:]

[From the Congressional Record, May 25, 1982]

> Mr. LATTA. By eliminating reimbursements for uncovered services, by delaying the medicare coverage until the first full month of eligibility, indexing of part B physician coverage deductible to the CPI, requiring medicare to become the second insurer rather than the first, when the recipient is covered by other insurance. Such costs savings, if agreed to, would certainly not harm the elderly or significantly reduce their benefits, as the uninformed have been saying for the last couple of days.

Chairman JACOBS. Are you familiar with proposals for cost containment, both by the business group on health, and I believe a consortium of labor organizations, including the Auto Workers?

Mr. WAXMAN. I am familiar with it in a general sense only.

Chairman JACOBS. You have not formed an opinion about such proposals?

Mr. WAXMAN. Let me refrain from giving an opinion.

Chairman JACOBS. Well, we are very honored to have your presence, and we are very edified by your testimony.

Thank you very much.

I believe our next witness is the Honorable Ron Wyden.

You are welcome to the committee.

STATEMENT OF HON. RON WYDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WYDEN. I don't want you to think I am going to become a permanent witness here. I would just like to discuss very briefly the question of medicare reform in general and the concept of prospective reimbursement, in particular.

Before I begin, I would first like to associate myself with the remarks of the gentleman from California, Mr. Waxman. I serve on his subcommittee, the Health Subcommittee of Commerce, and he has outlined very eloquently and specifically the job that we have got in front of us.

Just five short days ago, this Congress approved a budget for 1983 that once again places the burden of budget cuts on the already bowed shoulders of the elderly and poor—a budget that asks our grandmothers to pay money they cannot afford for health care costs that can be prevented.

Medicare reform is needed—and now. But wholesale, butcher-block cuts that adversely affect seniors are not the answer. A carefully thought-out restructuring of the medicare program is—and prospective reimbursement is a central component of such an effort.

I would like to ask you the question of what I think sums up the concept of prospective reimbursement. If you sold your services to the Government and it guaranteed to pay your bills no matter how much you increased your costs, would you look for ways to be more efficient?

The answer to the question is obviously no, and, at the same time, that is how the medicare program was billed for more than $30 billion in 1981 by hospitals and other health care providers.

After each service was provided—tests, physician visits, injections, et cetera—medicare picked up the tab. Under this system of piecemeal payment, called cost-based reimbursement, providers had no incentive to save money—and all too often, they did not.

And why should they? Instead of encouraging efficiencies, the cost-based reimbursement system actually encourages costly, inefficient methods of doing business. If a hospital uses less ancillary services, it is paid less. If it uses fewer days in the hospital, it gets paid less.

In sum, the current system forces medicare providers to grab for every dime—and still lose. They lose, because no matter how much they get paid by the Government, it is never enough to cover all the costs associated with hospitalization.

And when the provider loses, the consumer loses, because part, if not all, of these disallowed costs are shifted to the private-pay patient or absorbed through other programs.

The result of this inefficient practice is the medicare program we have today—an overburdened, structurally unsound program that the system's trustees predict will go broke sometime between 1986 and 1991.

The result is a program that does not add up—for providers, consumers, or Government.

But I am not here today to peddle a story of gloom and doom. If I thought nothing could be done to resuscitate the drowning system, I would not have come at all.

I do think something can be done to reform medicare in a responsible manner. That something is prospective reimbursement—the subject matter of a bill I introduced last winter, H.R. 5084.

Complicated name aside, prospective reimbursement has a singular goal—to change the inefficient way in which we reimburse providers under the medicare program.

Prospective reimbursement works by giving providers incentives to sit down with the Government—before the care is provided—to come up with a reasonable health care package that would be approved by the Secretary of Health and Human Services.

The possibilities for prospective reimbursement are endless.

Methodologies could vary from plan to plan. One plan could be hospital-wide, while another could be based on individual patient costs.

For example, a hospital group might agree to accept a specific rate from medicare for each heart surgery, or each concussion. The hospital then would collect the agreed-upon amount when a medicare or medicaid patient having that problem was treated.

Or a hospital group could set up a per capita charge similar to a health maintenance organization [HMO] whereby they would agree to serve a certain number of patients for a fixed amount.

The beauty of prospective reimbursement is that it would let hospitals know how much they had to work with that year.

As such, it would free them from burdensome paperwork—free them to figure out ways to cut costs such as by cutting back on use of ancillary services by enforcing shorter lengths of stay or by emphasizing more outpatient treatment or sharing services with other hospitals.

Under my bill, hospitals also are allowed the flexibility to come up with the prospective reimbursement plan that works best for them.

H.R. 5084 recognizes that what may be good for one group of hospitals may be bad for others—that what works in Dubuque may not work in San Francisco, and that what works in San Francisco may not work in New York.

Under our current system, 30 prospective reimbursement plans have been developed. They range from insurance-based plans to statewide rate-setting plans.

They all use different methodologies to suit their specific needs, and all save from 2 to 6 percent over the cost-based reimbursement system.

Prospective reimbursement is not just some wild-eyed idea I pulled out of thin air. Groups as disparate as the Gray Panthers and the Health Insurance Association of America have rallied behind the concepts of prospective reimbursement.

The National Association of County Organizations [NACO] has even gone so far as to offer to try to raise private planning funds to help some public hospitals develop prospective reimbursement plans.

These groups are supporting prospective reimbursement because they are tired of the disincentives of the "old cost based reimbursement" system.

They are tired of a system that wastes money and benefits no one.

Mr. Chairman, we cannot wait any longer for reform in medicare's reimbursement system. The administration's rumored prospective reimbursement proposal is so long-overdue that it reminds me of the old marquee at the movie house: "Coming Soon."

We need prospective reimbursement and incentives to change medicare which currently rewards inefficiency, not more butcher-block cuts that adversely affect the health of the elderly.

I hope the committee will place the House-passed medicare cuts on the shelf and take up my legislation or a similarly responsible approach that moves us in the direction of real medicare reform.

Thank you very much, Mr. Chairman.

Chairman JACOBS. Thank you, Mr. Wyden.

Mr. Rangel.

Mr. RANGEL. I want to indicate that I support your proposals, and I hope we will be able to bring it before our committee soon.

Mr. WYDEN. I thank my colleague.

Chairman JACOBS. Mr. Gradison.

Mr. GRADISON. I would also like to thank the gentleman from Oregon for his very useful testimony and for his leadership in this issue.

Would you hazard a guess as to how much we could save from this plan, and how long it would take to have it in effect on a nationwide basis?

Mr. Wyden. It would probably take a year to implement nationally.

As I say, prospective reimbursement programs are in effect. There are 30 different plans, and eight programs, State programs—Arizona, Connecticut, Maryland, Massachusetts, Minnesota, New Jersey, New York, and Rhode Island have reduced the rate of increasing expenses by 2 percentage points a year, and in some cases by as much as 4 to 6 percentage points, and I think in a year we can have prospective reimbursement program onboard, and I am prepared to amend my legislation, H.R. 5084, to say that any group of hospitals that has not moved to a prospective reimbursement plan within a year would be required to do so after a year's time had gone by, and they would be given a choice—had they not set up their own—of several plans developed by the Secretary of Health and Human Services.

So I think we give the hospitals a year to develop their own prospective reimbursement plan and there would be a 2 to 6 percent savings in the annual cost to medicare and medicaid.

Mr. Gradison. Are you suggesting, then, that there would not be a single uniform plan, but rather a variety of plans, and the institution would decide which one it wanted to live under?

Mr. Wyden. I suggest flexibility is the key to develop prospective reimbursement.

What works for a hospital in Mr. Rangel's district in New York may not be at all appropriate for your district in Ohio, or my district.

What I am suggesting is, let's give an incentive now for providers to go to this kind of system. Let's give them a year to take advantage of that incentive.

If they don't do so in that year, let us then say you are now required to junk this system that is cost-based, rewards inefficiency and, at that point, you should choose from a variety of alternatives developed by the Secretary of Health and Human Services.

Mr. Gradison. Thank you very much.

Chairman Jacobs. Mr. Duncan.

Mr. Duncan. No questions.

Chairman Jacobs. Mr. Anthony.

Mr. Anthony. No questions.

Chairman Jacobs. We are honored to have the Honorable Mary Rose Oakar, from Ohio, "Mother Knows."

STATEMENT OF HON. MARY ROSE OAKAR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Ms. Oakar. Mr. Chairman, and members of the committee, let me submit my entire testimony for the record, if you will, and I want to thank you very much for your gracious invitation to testify before you.

As all of you know, the majority of Members of Congress, in my opinion, reflecting the will of the American people, in particular, the elderly and disabled, supported my amendment to fully restore medicare as it related to all three substitutes in the original budget proposals. Of course, the Rules Committee did not allow me to submit my amendment again; therefore, we will never know whether the courage of the Congress would have prevailed once more. But I really feel very strongly that the American people, given a choice of options, do not want to see cuts in medicare as it relates to its impact on older Americans and our disabled Americans.

This Nation made a commitment to our elderly and disabled to provide protection against the high costs of their medical care. Addressing the medicare situation and the medicaid situation in a piecemeal fashion, as was done in the budget, both by the Senate and by the Latta budget on the House side, really affects the health care of older people. Twenty-five percent of their needs relate to health care.

I have a very interesting district which, in a way, is a microcosm of the country. I have a lot of very, very poor people in the district that I represent. I have people of moderate income, and I have older Americans who were once wealthy. What is very interesting is, when people in this country become old, whether they were middle-class or wealthy in the past, they suddenly find themselves poor. That is why it is so very, very tragic to see those dramatic cuts toward older people in an area that they can ill afford.

Now, I want to indicate that my own feeling is that we do not do enough in this area of medicare, and that is one reason why we have so many high costs. We do very little in the area of preventive health care.

For example, you and I know that medicare right now covers between one-third to 40 percent of older people's needs. It does not cover eye care and foot care and medication.

As a matter of fact, in order to get a free blood pressure check, you have to prove that you have high blood pressure, so we really are not addressing the preventive health care area which, in my judgment, would indeed assist in bringing down the costs of medicare.

I personally feel that we ought to try to adopt a "part C" that Senator Pepper and some of us have supported which would provide for a comprehensive policy of older people by providing for some of these services.

I know in my own area, and across the country, any older people who are able to afford supplemental policies have dropped those policies, because within the last 6 months, the commercial insurors for supplemental policies across the Nation have increased their policies between 50 to 120 percent. So, for the average older person, medicare is it, and it only covers 30 to 40 percent of their needs.

In addition, I think older people, like most other poor people are bearing the extent of the budget cuts in a much more dramatic degree than any other group in this country.

Of last year's medicare cuts 80 percent were placed directly on the backs of the elderly. If anybody wants to argue that the real intent of cuts was to get down on health care costs, the fact of the matter is that we did indeed decrease their coverage. It is interesting to me, if you take a look at the cuts in the Latta budget of last year, which I believe was a little bit over $1 billion dollars, the

Senate version which is over $4 billion, and our version, which is over $3 billion—I can't imagine how it will affect our older and disabled people this year.

Take a look at where the cuts were last year.

The cuts existed in the area of repealing the alcohol detoxification reimbursement program.

One of the other areas was to repeal continuous enrollment. Medicare recipients are only allowed to enroll for optional part B of any year, under the prior law they could enroll at any time.

Is that really where the high costs are, not allowing people to enroll when they feel they should enroll?

As a result, many older people for a 9-month period will probably have no access to health care. Take a look at the other areas of reductions.

If our Congress and the administration were really sincere at getting at the nipping-at-the-bud, I don't think they would pick on the nurses. That is another area of reduction where they reduce the differential for the nursing costs from 5 percent to 8.5 percent.

The fact of it is, nurses are among the lowest paid individuals in the health delivery service. Another area which is rather unbelievable to me is the area of home health care, a cut in that reimbursement area.

If there is anything we need more of and anything that would diffuse the cost of health care, it would be in the area of home health care. It is much less expensive for people to have their minimal needs treated at home than it is to put them in a hospital. So I want to suggest to you there seems to be a certain point of departure, a certain bias on the part of the administration and Congress toward doctors and hospital costs. I am suggesting to this committee, if we are really sincere in wanting to get at the real culprits, in terms of where the real costs are and the heavy money is, we would not go picking on the nurses and home health care and the alcohol detoxification program. That is why I say to this committee, that while so many Members of Congress said we are really not going to touch the older Americans' health care, the fact of it is, just judging by what happened last year, they will be affected, and affected deeply—so will our disabled people. Remember, they are also the ones that experienced a $2 billion reduction in their food stamp program, and cuts in the Older Americans Act, which were made last year. Other cuts include half a billion dollars in social services programs that relate to older people and a hundred million dollars in community action programs and community service programs that relate to older people. This year we cut their job program. They have really taken it in the neck in terms of our budget. To do what we did in terms of medicare is very, very unfortunate.

The question is, what is the solution, and how can we really show that we want to be equitable and fair in our treatment of our disabled and our older people?

One thing that we might want to keep in mind, is that the President did appoint a Social Security Commission that was supposed to look into the area that is under the auspices of the Social Security insurance program, of which part A, medicare part A, exists.

Now, I don't quite honestly understand why this haste in cutting medicare, if indeed we were supposed to wait for their recommendations.

One area that I might suggest is this: I think there has to be a national movement to advertise the areas of rising health-care costs. I don't think that in order to get at those who really are responsible for the bulk of the costs, that you just cut medicare.

What we ought to be trying to do is provide ways to stop the spiraling costs generated by the health care providers by possibly having a well-publicized, initially voluntary approach of what suggested fees might be, in terms of the areas under which medicare provides.

I also think other approaches would help. And I think we ought to bring in the AMA to testify and ask them how they will contribute to this voluntary approach. I think we ought not to just deal in terms of medicare, but we ought to have all the providers, Blue Cross, Blue Shield, the Kaiser people, the hospitals, et cetera, come in and testify in terms of what their contributions might be.

I also think we ought to find ways in our country, I think this really challenges the imagination of this committee, which is so crucial to the medicare area; we ought to find ways to establish programs around the country which indeed will take care of the needs of older people by doing things as providing an opportunity for a physical every 6 months, the opportunity for frequent blood pressures and the opportunity for an examination of one's circulation in blood count.

We know that 25 percent of older people suffer from anemia just because they are not aware of the fact their diet needs a little more supplemental iron, and so forth.

We ought to be able to do this in one of the wealthiest countries in the world. We ought to have pools of hospitals and doctors who really want to be ethical and participate in the medicare program.

In this way, if we really made this a national commitment to provide health care for the most vulnerable of our people, the elderly and our disabled, we would see that the spiraling costs of the medicare area would be whittled.

I know this can't be done overnight, and I know, also, that this committee is now faced with the enormously difficult task of implementing the cuts, providing the conference report passes the combined Latta and Senate budgets. But I would ask you to keep in mind one factor. Older and disabled people are not responsible for the health care, and the high health care costs. They are not the culprits, and unless you really get at the source, unless you put the pressure on the source not to abuse the system, then I don't care how much you cut medicare, you are not going to protect the interests of the taxpayer on our older and disabled citizens.

I would be happy to respond if you have any questions.

[The prepared statement follows:]

STATEMENT OF HON. MARY ROSE OAKAR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. Chairman, thank you for this opportunity to testify before your esteemed Subcommittee.

As you know, I fought tooth and nail during the first round of budget debates to fully restore the proposed cuts in Medicare. Although, we were successful in amending all three substitutes, we were unable to pass one of them.

During the second round of budget debates, I testified before the Rules Committee again asking for a rule permitting amendments to restore funding for Medicare. This time, however, amendments such as this, were not allowed and as a result we were forced to choose between the Latta Substitute which cut Medicare by $11.5 billion over a three year period and the Jones Alternative which reduced Medicare outlays by $6 billion over the same three year period. And as we all are acutely aware, the Latta Substitute prevailed. We are now faced with a difficult conference situation with a Senate passed Medicare cut totaling over $18 billion for 3 years.

I feel as strongly today, as I did two weeks ago, that cutting a nickel from Medicare is cutting a nickel too much. This nation made a commitment to our elderly and disabled to provide protection against the high cost of their medical care. To reverse that commitment is inhuman, indecent and immoral. I have an interesting district, part of Cleveland and some fairly wealthy suburbs. All the older people tell me the same thing: once they were middle class and now they're poor. The political reality is, however, that Members of Congress voted to partially neglect that commitment by supporting the Latta amendment. And, despite recommendations and assurances that the savings will not result in increased expenses for the beneficaries, that is exactly what will happen because whenever you cut Medicare, it will ultimately cut services to older people. Furthermore, significant gaps in Medicare coverage add to the already increasing out-of-pocket expenses. Medicare does not provide benefits for eyeglasses, dentures, hearing aids, prescription drugs or basic preventive services. Its coverage for mental health services is extremely restricted. Indeed, only ⅓ of the medical needs of the elderly are now covered by Medicare. This is a mere pittance of their total health-care needs. What's more, the Medicare supplementary contracts offered by commercial insurers have increased nationally 50 percent to 120 percent. They are now out of the realm of most older and disabled persons who have no other access to health care other than through Medicare. In addition, this country's elderly are now bearing the burden of last year's budget cuts. Eighty percent of last year's Medicare cuts were placed directly on the backs of the elderly.

For example, deductibles were increased. In addition, reimbursement for home health care was reduced, to name just two of the recent changes. Proposals to reduce reimbursement for home health care are basically counterproductive. It reduces the incentives for Medicare beneficiaries to use these more cost-effective services rather than more costly skilled nursing facility care. Based on what happened last year, the Medicare cuts that were implemented first were the ones affecting the beneficiaries. The proposed savings affecting providers have yet to be put into place, so I am told. If this year is anything like last year, then the beneficiaries will once again take the brunt of the cuts. The Food Stamp Program, which affects 2 million elderly, underwent a $2 Billion reduction. Reductions were made in the Older Americans Act; ½ Billion Dollars was cut from the Social Services Block Grant and more than $100 Million was taken from the Community Services Block Grant.

And now your subcommittee is faced with the difficult task of making cuts in this vital program. I would have preferred, and thought it was the intent, to delay any reform in the Medicare program until the President's Social Security Commission had completed its investigation and submitted its recommendations. I think we destroy the whole purpose of the Commission by making these reductions now. During my testimony before the Rules Committee, the Acting Chairman, Senator Pepper, indicated that discussions had taken place and assurances had been made that language would be incorporated in this budget resolution to reflect that the savings would come from provider services and not beneficiary services. If cuts must be made, I urge this Subcommittee to keep this utmost in mind as you begin the arduous task of achieving the required reduction.

Health care costs cannot be controlled on the backs of the elderly and disabled. If we are to stop the spiraling cost of health care, we cannot cut Medicare in a peripheral fashion. We cannot continue to take benefits from the elderly. We must go after rising health costs in a comprehensive fashion—across the board. The elderly are not the culprits of rising health costs. We must go after the culprits. The doctors who run up exhorbitant costs for Medicare and abuse the program must be curbed—we have all read about such abuses. Ways to stop the spiraling costs generated by all the health care providers must be found. Possibly a well-publicized, voluntary approach might work; however, there should be some mandatory controls as well.

None of this can be done overnight; we considered these problems in the last Congress as well. However, I do feel we should proceed with a comprehensive approach, and I believe the health care providers and Congress itself will be receptive. Our elderly cannot continue to bear this burden. I stand ready to work with you

Chairman Jacobs. Thank you, Representative Oakar.

Mr. Gradison.

Mr. Gradison. I have no questions. Thank you.

Chairman Jacobs. Mr. Duncan.

Mr. Duncan. No questions.

Chairman Jacobs. Mr. Anthony.

Mr. Anthony. No questions.

Chairman Jacobs. Are you familiar with the cost containment proposals by the entities I mentioned a moment ago?

Ms. Oakar. Yes.

Chairman Jacobs. Have you formed an opinion?

Ms. Oakar. If it is across the board, that is the approach we ought to go toward, but when you just single out the medicare program, it is very unfortunate.

Chairman Jacobs. Thank you. I will say for the record that some of us admired the true grit that you displayed on the floor the other day, and we thank you for your testimony.

The next witness is the Honorable Richard Gephardt, from St. Louis.

He is a member of the committee.

STATEMENT OF HON. RICHARD A. GEPHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. Gephardt. Thank you, Mr. Chairman. I appreciate the committee holding these important hearings on this very difficult subject matter, and I know that the committee is going to do a very thorough job in trying to address the questions that are being asked by the budget process.

The best thing I can do today is to give my evaluation of how we all might try to approach the witnesses that will be here today who are much more knowledgeable than I am about the issues before us, and the kinds of questions we should be asking and thinking about as we hear and try to understand their testimony. The basic question is, what cuts in outlays for the fiscal year 1983 medicare program can we make that least adversely affect the health status and the pocketbooks of the poor and the elderly?

Another question is, will the cuts impair the quality of the health care delivery system?

To answer these basic questions, responses to additional questions will be required.

What is our current health policy? Where is the Federal money going? Who is benefiting from the purchased services? Do tax expenditures play an important role?

You have invited Dr. Wilensky to speak about the fine research she has done in this area, and I hope she will answer these questions. As she does, I urge you to consider what we want for our country.

Other questions then come to mind such as: Is regulation a better short-term or long-term modifier of behavior? If, as I believe, it is much more effective in the short term, what are some of the more effective long-term methodologies that can be expected to produce the desired changes in the way we pay for health care?

Most of us agree that we should and can get a better buy in the health-care market for the Federal dollar. Some feel that we should decrease the Federal role and the flow of Government dollars. Others wish to use similar amounts of money to buy more care.

But the implication of all these comments, which apparently are diametrically opposed views, is that the system is inefficient. I don't mean that the doctor's office is poorly managed, or that the insurance companies are taking too large a profit or that hospitals are living in a bath of money—these parts all may be efficient, but the system as a whole is inefficient. More positively stated, the same high health status of Americans can be achieved by spending less.

Over the years, we have created a series of perverse incentives influencing all sectors in this market that lead to the use of the most costly facilities of the system. Frequently, hospitals are the site for services that can be provided as well in ambulatory settings. Such malutilization does not enhance quality, just the price. We must change such behavior of the system by eliminating these perverse incentives.

Some may want to do it through a prospective payment scheme. Congressman Wyden was here and made an eloquent statement for prospective payment. Hal Cohen can tell us about his extensive experience in this area in Maryland.

Some may wish to establish a marketplace where people, not Congress, determine their own health policy using some of their own after-tax dollars. I support such a concept.

I believe that medicare eligible citizens, too, have the right to choose an annual health care plan. This could easily be accomplished with a voluntary medicare voucher plan. Now, most senior citizens cannot even join their local HMO. Further consideration of other ways to encourage consumers to be more cognizant of costs should be strongly considered. One way would be to set a limit or cap on the amount of the tax-free contribution employers make to employee health plans.

I have studied the health care system only for a few short years. I don't pretend to know all the answers. I do know that it is ill. I do know that even very carefully selected cost-saving regulation will harm beneficiaries and the system.

Unless you want to go through this destructive process over and over again, let me urge you in the strongest terms, listen with one ear to the now—the present—and with the other to the future. Evaluate carefully a voluntary voucher for medicare, a competitive marketplace, a prospective payment scheme, and a cap on tax-free fringe benefits.

Look for a system that is self-correcting, rather than one that requires yearly, prohibitively expensive and distasteful maintenance.

The previous speaker, Congresswoman Oakar, pointed out, last year we cut $1 billion from medicare and $1 billion from medicaid. For this year, budget resolutions, if you split the difference between the Senate and the House, we are going to cut $3.6 billion from medicare and a half a billion dollars from medicaid. Simple arithmetic makes you understand, if we do that, over the 2-year period we will have cut $4.6 billion from medicare and $1.5 billion from medicaid.

I simply ask you to recognize the fact that while we have been cutting these programs to this extent, if we do nothing on the tax side, we will have done all of our cutting in health care on the poor and the elderly and will have done no cutting on the part of the budget, that is, tax expenditures for health care that goes to the population that can more easily withstand cuts in the budget in health care.

So I urge the subcommittee, as we look at how we are going to cut programs designed to help the poor and the elderly, that we consider also budgetary cuts that would affect the taxpayers of the country who thus far have withstood none of the health care cuts dished out by the Congress.

There are a couple of ways to do it: One is to require Federal employees to pay HI tax, another way is to impose a cap on the deduction or exclusion on employer-paid health benefits to the working population.

I would suggest to you that the tax cap is going to be evaluated by the Senate Finance Committee as part of its revenue enhancement measures, and I would suggest that that could be looked at as part of your proposals to cut medicare, and to come up with some cuts in the health-care area that don't adversely affect the poor and elderly. Even though that is not directly in your jurisdiction, I would suggest that that could be looked at as part of your overall revenue enhancement or budgetary deficit reduction package.

To further amplify that point, let me just explain, as you well know, medicare costs $49 billion in round numbers now, and medicaid costs $19 billion. The tax expenditure for working employees alone costs the Government $25 billion in lost revenue. So just in terms of their parts of the budget, the tax expenditures are very large, almost half of the size of the medicare budget.

In conclusion, I would urge that this subcommittee look for two basic goals in trying to administer these cuts.

First, as I have just said, the cuts must be fair. We should look at the beneficiaries, the taxpayers and the providers, the hospitals and the doctors, as we try to fashion a series of cuts that affect all of them, more or less, in an equal way Then, as I think my testimony points out, as we do all this cutting and changing and taking things away from people this year, we also within this context should try to put something on the table that will give people a way out in the long-term. Give beneficiaries an option, like the voucher, like prospective pay, or the HMO voucher, so that people can, if they are faced with cuts, at least have a way to try to get more efficiently delivered health care so they don't have to take all of this budget-cutting in the form of reduced benefits or personal financial burden.

It has been a great pleasure to be here, and I appreciate the work that this subcommittee is doing.

I thank you for your time and attention. I will be pleased to try to answer your questions.

Chairman JACOBS. We appreciate your statement.

Mr. Rangel.

Mr. **Rangel**. Thank you.

What happened, Mr. Gephardt, to your competition bill? Wasn't that embraced by the administration? At least they suggested that that was going to be the bill.

Have they conferred with you as to whether or not they are prepared to support it or introduce similar legislation?

I hate to waste time with it if it will not come before the committee.

Mr. **Gephardt**. They have, I think, in concept supported a bill like the bill I put together. They also have been working on their bill, which probably will be a little different.

They have not yet brought it to the Hill, as I hoped they would and still hope they will. They have been preoccupied with the budget and have been unwilling to come out with long-range proposals.

As I have said in my testimony, I don't know how we do short-term regulations or cuts in benefits without at least trying to comprehend what we want for the long haul.

I don't personally believe that cuts in benefits are the answer to the problems of the health care system.

I don't believe 223 regulations are a long-term solution. As the gentleman knows, we have been round and round on subjects like this. My hope is that both the administration and the subcommittee will consider some long-term solutions and that the administration will come here before the subcommittee and tell the subcommittee what it feels its long-term views are.

Mr. **Rangel**. But you believe that this committee, the subcommittee or the full committee, should look into whether or not employers should receive tax exemption for comprehensive health programs offered to employees, and/or employees should receive some type of financial reward if they accept more restricted health plans?

Mr. **Gephardt**. I think that there is a whole group of issues that you ought to examine, we ought to examine, as we are cutting medicare. I can't justify in my own mind for the second year in a row making all these marginal budgetary cuts against the poor and the elderly alone.

I simply believe that both for long-range efficiency in the system and for equity between groups that we need to address the tax issues that affect the employed as well as how the medicare and the medicaid programs function.

Mr. **Rangel**. Well, what happens if a young man believing that he never will become ill, receives a lesser package, an economy health package, and certainly the employer couldn't go beyond a certain dollar limit because he would not receive tax exemption and we also provided the incentive for the younger person to receive additional income for receiving the lesser package?

And he does get sick, and he doesn't have adequate coverage and he is a low-income worker. What happens to him?

The same question would apply with the voucher system. We decide what a person can buy with the voucher. That makes it competitive.

So they go around and they shop and they find some doctor that gives the economy package and then they get sick and they don't have enough coverage and they get the best possible, the most economic package possible for that.

Assuming it is an aged person that is poor, the working poor, what happens in the system with these people that did everything you would want them to do in not buying more coverage than we believed they needed?

Mr. GEPHARDT. Two things: One, I would structure the voucher and the tax exclusion so that everybody in the country would have to buy a plan that at least has a catastrophic feature that would protect them beyond a certain amount out-of-pocket per year.

I would leave no one in the country without that protection.

Second, I don't think it is altogether clear that even the young and the well are going to want to choose cheap, large co-pay plans.

If the polls are right, if the evidence is correct, Americans continue to want comprehensive care above everything else. Above wages. Above housing. Above everything.

I believe what we are trying to do with this kind of a program is to offer Government incentives only to the extent of efficiently run health care plans and if people persist in inefficient fee-for-service plans, if you will, then they got to dig in their pockets to come up with the money to pay for that.

I don't think Government should overly subsidize the system and really give incentives for people to go in to what I think are inefficient plans.

I think we have evidence today that there are efficient ways to deliver health care and more efficient ways to deliver it. I think the Government ought to be giving subsidies for the cost of efficient plans, but not more than that.

Mr. RANGEL. How would the voucher holder be able to determine which health programs are efficient and which are inefficient?

Mr. GEPHARDT. Efficiency yield, the ratio of more health for the dollar. My plan allows consumers to find plans in their own communities that are efficient and are giving them more for the money in terms of health. All consumers, including the elderly, are good at that. Furthermore, I think it is impossible from Washington to figure out a best way to select for every person in all places in this country.

I think there has to be a way of doing this on a regional basis.

One way to do this, it is a different way than mine, but I think it is a very inventive idea, is Ron Wyden's idea of having prospective pay, that would be the Government contracting with providers that are doing a good job but do it on an area-by-area basis rather than, as the AHA and insurance industry wants, on a nationwide basis. That allows you regional sensitivity.

I think what you have to look for is a way to reflect the diversity of this country and the differences that exist in different places.

I think you can do that. I think both consumers and the Government can find plans that are really giving a dollar's worth of care in health.

Mr. RANGEL. Well, I certainly hope that whatever plan the administration comes up with or the ones you will be pushing through the subcommittee and committee make certain that the recipient is protected and that you don't offer economy packages without making certain that if a mistake is made, that there is not some fallback position.

Believe me, it wasn't until I reached 50 years old that I started looking at pension plans and it appears to me that when you put on the employee, the lower paid employee—because this would not affect the executives or higher paid people because they buy what they want or feel they need—but when you ask them whether or not they want the $5 or $5 in coverage, it seems to me they would rather have the $5 in their pocket.

In any event, Mr. Gradison.

Mr. GRADISON. Thank you very much.

On that point, I might add with regard to the medicare vouchers that we have been working on, that before a package could even be offered on a voluntary basis to a medicare beneficiary, they would have to offer the services available under medicare today.

So in order to get people to sign up, the theory of it, at least, is that the package, whether offered by an insurance company or group of hospitals, doctors or HMO's, would have to offer something more.

After all, it is a voluntary plan and those who are covered by medicare today could continue just to put the present system in their package and would not be well-advised to move to something else unless they would get more.

Every plan would have to be approved in advance by the Secretary and one of the determinations which would have to be made was that that determination was made, that it provides everything available if the medicare beneficiary continued under the present system where certain services listed in the law are covered.

I want to take a moment to thank the gentleman from Missouri for not only his testimony, but his leadership. He certainly put the shorter term questions which we face this morning, and will be facing in the subcommittee in the weeks ahead, in a very valuable long-term perspective.

I respect his contributions in the past, as well as his assistance to us this morning.

Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Anthony.

Mr. ANTHONY. No questions.

Mr. RANGEL. Thank you very much.

Mr. GEPHARDT. Thank you, Mr. Chairman, and members of the committee.

Mr. RANGEL. Dr. Carolyne Davis, administrator, Department of Health and Human Services.

Thank you for appearing here today, we hope you can come up with suggestions that the committee can support.

Your statement will be entered in the record and you may proceed as you see fit.

STATEMENT OF CAROLYNE K. DAVIS, PH. D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY PATRICE H. FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY; AND DENNIS FISCHER, DIRECTOR, HCFA OFFICE OF MANAGEMENT AND BUDGET

Ms. Davis. Thank you, Mr. Chairman. I appreciate the invitation to return to the committee and continue our dialog.

We, as well as Congress, are concerned about maintaining the strong, stable medicare program, while we begin to work together to save significant program funding in this particularly critical budget year.

Let me first pause to introduce my two associates. With me today are Patrice Feinstein, the associate administrator for policy, and Dennis Fischer, the director of the Office of Management and Budget in HCFA.

First, I would like to stress more strongly than I did in my past appearances before this subcommittee that we must control rising costs in the medicare program. If we don't slow the spiral in health-care cost increases, the medicare program is not going to be able to afford the services which we have in the past taken for granted.

We must insure a stable program for our beneficiaries, not only for now, but also in the future.

All of us recognize that health care costs have been growing faster than the general rate of inflation in the economy and, indeed, the medicare program has absorbed a greater share of total expenditures.

In 1966, medicare expenditures were $3.4 billion. They have been growing at an annual rate of 21.4 percent over 1979 to 1980. I point out that for 1982, medicare expenditures are projected to be $49.8 billion, which translates to $4.1 billion per month which is more than the total medicare expenditures in 1966 of $3.4 billion.

We estimate that, under current law, medicare expenditures could reach $147 billion in 1990. That is an astonishing 302 percent increase from 1982.

I know you are aware of the 1980 Medicare Hospital Insurance Trustees' Report which projected that even with the scheduled increases in the social security payroll tax, the hospital insurance trust fund would go broke shortly after 1990. The trustees also estimate that because of higher-than-originally-estimated inflation in hospital costs, program outlays will exceed income beginning in 1985.

Those projections also make obvious the need to develop reform in order to assure the current effectiveness and long-term stability of the medicare program.

I think we must keep in mind that there is a difference in the nature of medicare and other social security programs. Medicare beneficiaries contribute to the trust funds for medicare through their payroll deductions and through payment of premiums. Medicare then pays health care bills for covered elderly and disabled.

But like many private health insurance plans, medicare does not pay the total cost for all services. Indeed, the statute mandates that the beneficiaries share in their health care costs through payment of deductibles and coinsurance amounts.

However, it is important to recognize that most of the money paid by the medicare program does go to providers of services. The chart clearly indicates that 67 percent of the total medicare outlays go to the hospital community, 24 percent go to physicians and other suppliers, 6 percent go to outpatient care, 2 percent for home health, and 1 percent for skilled nursing facility care.

Medicare is a reimbursement program and we should distinguish that reimbursement program from direct-payment programs such as social security where benefits are paid directly to the beneficiary by check.

In order to save significant amounts of money in the medicare program, we do not need to cut benefits. Rather we can focus on necessary changes in which we pay for services to the provider communities.

Medicare reforms, I think, are needed in both short- and long-range areas. I believe there are three immediate responses which are rational and sound and focus primarily on the providers who are the most responsible for the enormous cost increases in medicare.

These reforms include changing the manner in which we currently reimburse providers, including hospitals and physicians, deleting current unwarranted subsidies, and increasing cost consciousness on the part of consumers.

I have discussed many of these proposals with you before this very committee and I don't propose to spend time today elaborating since my statement does that.

Let me say our No. 1 priority should be to reduce the rate of increase in hospital costs.

Second, because medicare outlays for physician services have risen at a rate of approximately 18 percent a year. We will direct much of our effort to reducing that increase, also.

Let me summarize by saying it is essential that we slow the intolerable increases in medicare expenditures. I think we both agree that prompt action is needed if we are to maintain the financial stability of the medicare programs.

Thank you.

[The prepared statement follows:]

STATEMENT OF CAROLYNE K. DAVIS, PH. D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

INTRODUCTION

Mr. Chairman, I appreciate your invitation to appear here today to continue our dialogue on how the Congress and the Administration can together maintain a strong and stable Medicare program while saving significant funds in this critical budget year. With me is Patrice Hirsch Feinstein, the Associate Administrator for Policy, and Dennis Fischer, Director of the Office of Management and Budget.

I would first like to stress even more strongly than I did previously in my appearances before the committee, that we must control the rising costs of the Medicare program. If we are not able to slow the spiral of health care cost increases, the Medicare program will not be able to afford services which we have in the past taken for granted. We must act this year to insure a stable program for beneficiaries now and in the future.

THE PROBLEMS

We all recognize that health care costs in the past several years have been growing faster than the general rate of inflation in the economy. The Medicare program and its 28 million aged and disabled beneficiaries absorb an ever growing share of the total expenditures for health care. Medicare expenditures in 1966 were $3.4 billion. In 1980 they were $35 billion, a 20 percent increase over 1979. Medicare expenditures in 1981 were $42.5 billion, a 21.4 percent increase over 1980. In 1982 under current law Medicare expenditures are projected to reach $49.8 billion, or a 17.2 percent increase over last year. Thus, Medicare expenditures have increased by a factor of 15 times since 1966. We estimate that, under current law, Medicare expenditures would reach $147 billion in 1990—an astonishing 302 percent increase from 1982.

As you are aware, the 1980 Medicare Hospital Insurance Trustees' Report projected that even with scheduled increases in the Social Security payroll tax, which finances the Fund, the Hospital Insurance Trust Fund would go broke shortly after 1990. The trustees estimate that, because of higher than originally estimated inflation in hospital costs, program outlays will exceed income beginning in 1985. These projections make obvious the need to develop reforms which will ensure the current effectiveness and longer term stability of the Medicare program.

THE NATURE OF THE MEDICARE AND SOCIAL SECURITY PROGRAMS

Before outlining the actions we believe must be taken to cope with increasing Medicare costs, I would like to stress briefly the major difference between the Medicare program and the Social Security Old-Age, Survivors, and Disability programs.

As you know, the Medicare program was enacted in 1965 to pay the health care bills of our nation's aged and disabled. The cost of these services are paid by trust funds to which Medicare beneficiaries contribute through payroll deductions and premiums.

Like many private health insurance plans, Medicare does not pay the total cost for all services. The statute mandates that beneficiaries share in their health care costs through the payment of deductible and coinsurance amounts. However, most of the money paid by the Medicare program goes to providers of services—67 percent to hospitals, 24 percent to physicians, and 1 percent to nursing homes in 1980. Thus, Medicare is a reimbursement program, as distinguished from a direct payment program such as Social Security, where payments are made directly by check to the beneficiary.

In order to save significant amounts of money in the Medicare program, we need not cut benefits. Rather, we can focus on necessary changes in the way we pay for services.

OPPORTUNITIES

Medicare reforms, both short and long range, are critically needed. We believe there are three immediate responses which are rational, sound, and focus primarily on providers who are most responsible for our enormous cost escalations in Medicare. These include: (1) reform the manner in which we currently reimburse providers, both hospitals and physicians; (2) delete current unwarranted subsidies; and (3) increase cost consciousness on the part of consumers. I have discussed many of these proposals with you before, but I want to stress some of the kinds of actions I believe are prudent and responsible public policy.

Our number one priority in the area of provider reimbursement reform should be reducing the rate of increase in hospital costs. Also, because Medicare outlays for physician services have risen at a rate of 18 percent per year, we must direct much of our efforts to reducing that increase. Possible ways of doing that include:

Limit the 1983 increase in the Medicare Economic Index (which determines allowable increases in physician reimbursement) to 5 percent. This would have a one-time impact on physicians, who would share the burden of slowing the growth of health care expenditures at a time of severe budget constraints.

Reimburse inpatient radiology and pathology services at 80 percent of reasonable charges (rather than the current rate of 100 percent). This change would result in reimbursement for such services which is consistent with other physician reimbursement.

Eliminate duplicate medicare payment for overhead expenses by refining physicians' reimbursement for services provided in hospital outpatient departments.

Reform hospital-based physicians reimbursement to simplify administration, eliminate reimbursement abuse, and establish effective constraints.

Delay the physicial fee screen update from July 1 to October 1.

A second area I would like to discuss encompasses proposals which would eliminate current unwarranted Medicare subsidies.

At present, cost accounting practices can result in the costs of medically unnecessary private rooms being subsidized by Medicare. We recommend computational changes to eliminate payments for such rooms—unless private rooms are necessary to the medical recovery of a patient.

The working aged proposal would eliminate the subsidy currently realized by employers who can now pass the primary costs of insuring the aged on the Medicare. Employers of Medicare-eligible workers would be required to offer employees aged 65 through 69 the same health benefits offered to younger workers. Medicare currently covers the major health expenses of the aged: Therefore, employers of person over age 65 are spared the expense of covering such persons fully under their employment-based plans.

We would also bring Federal employees under Medicare Part A. For the first time, Federal workers would become eligible for Medicare based on their Federal Employment. Most workers in employment covered by Social Security are subject to the Hospital insurance tax during their entire career. Federal employees, however, may earn the same coverage with relatively few years of work subject to the tax. We estimate that more than half the Federal retirees over age 65 currently qualify for Hospital Insurance Benefits based on their own non-Federal employment or that of a spouse.

A final area which we believe deserves careful consideration is that of making consumers more cost conscious. As we are all aware, third party programs such as Medicare and private health insurance tend to insulate consumers that the reality of medical care cost increases. We believe that it is appropriate to assure that greater pressures are brought to bear on providers directly from consumers, and we urge careful consideration of proposals which would have this effect. Two particular suggestions are:

Index the Part B deductible to the consumer price index beginning in 1983. Despite a huge percentage increase between 1972-1981 in program expenditures per aged enrollee, there was no increase in the deductible amount until this Congress decided last year to raise it from $60 to $75. Indexing to the CPI would result in a deductible of approximately $82, far lower than that which would result if we tried to maintain the 1965 relationship to program cost. This proposed change would be consistent in concept with the original decision of Congress to index Part A deductible and coinsurance amounts.

Require minimal coinsurance on home health services under medicare. We believe a reasonable coinsurance should be required for home health visits. (In 1979 persons receiving Medicare Home Health benefits used an average of 23 visits each.) A small increase in cost-sharing is reasonable and we do not believe it will deter the use of necessary home health services. However, coinsurance should deter unnecessary utilization: A recent General Accounting Office (GAO) audit found that 27 percent of home health visits covered by Medicare were of questionable necessity.

OTHER REIMBURSEMENT REFORMS

The greatest health care cost escalation we are now seeing is in the hospital sector—that increase was 18.3 percent in 1981. As I indicated earlier, hospital services account for 67 percent of Medicare expenditures. Our number one priority therefore should be to reduce that rate of increase. In addition to the more vigorous and targeted utilization review program, the Administration proposed to reduce reasonable costs by two percent. Other approaches are also being widely discussed in the Congress and within the Administration and we anticipate continuing these discussions during the upcoming legislative process in order to achieve the economies we all recognize are necessary.

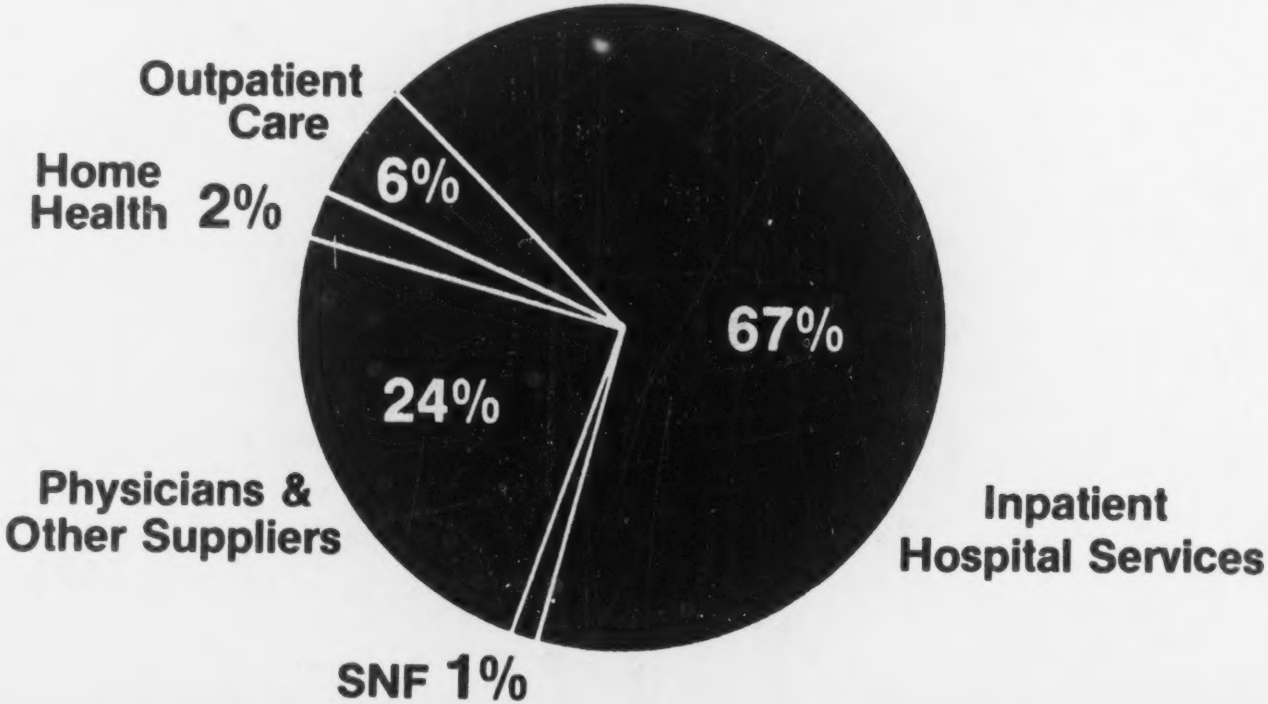
SUMMARY

It is essential that we slow the intolerable increases in Medicare expenditures. I believe strongly that the ideas I have discussed illustrate ways to cut costs and I hope you will agree that prompt action is needed if we are to maintain the stability of the Medicare program.

Mr. Chairman, I would be glad to respond to any questions you or the members of your committee might have.

MEDICARE FY 1980

(Total Part A & B Benefits $33.9 Billion)



Chairman JACOBS. Thank you, Dr. Davis.

Mr. Rangel.

Mr. RANGEL. Thank you, Dr. Davis.

Do you envision one day perhaps the Federal Government could get out of the health-care business altogether and let the local and State governments handle this?

Ms. DAVIS. Do I envision the Federal Government would find a way in which it would get out of health care totally?

Mr. RANGEL. Yes.

Ms. DAVIS. No, I think the American public clearly spoke many years ago when the medicare and medicaid programs were designed. I certainly wouldn't envision that there would be a time that we will not be engaged in the Federal responsibilities.

Mr. RANGEL. You see that as a legitimate Federal responsibility to the sick and the aged rather than a local responsibility?

Ms. DAVIS. I think it is a shared responsibility.

Mr. RANGEL. You think that the Federal Government is carrying too much of the share and that more of these decisions should be made at the local level? Local and State level? Get Government out of it, the Federal Government out of it as much as possible. Eliminate the red tape.

Ms. DAVIS. In the long run, we are certainly trying to give more of the decisionmaking back to the local level. It is our hope, as we address the development of a prospective payment system, that giving back the initiatives of decisionmaking to individual hospitals would improve their efficiency and effectiveness.

Mr. RANGEL. Mr. Latta indicated that in the debate on the budget that he had received a letter from Secretary Schweiker indicating that the passage of the budget would not impact on the beneficiaries. He referred to a letter from the Secretary.

Are you familiar with a letter that would have been sent to Congressman Latta?

Ms. DAVIS. Yes.

Mr. RANGEL. Are you familiar with the letter that the Secretary sent to Mr. Latta indicating that the passage of the budget——

Ms. DAVIS. I have not seen a copy of it.

Mr. RANGEL. Is anyone familiar with a letter being sent that Mr. Latta referred to on the House floor indicating that the passage of his budget would not have any impact on present beneficiaries?

Ms. DAVIS. I was informed of the fact that there were discussions relative to it. I have not seen the specific letter, per se, but I am certain that those areas identified in the Latta proposal could be achieved. They are reasonable and achievable.

Mr. RANGEL. They are achievable, but they do increase the costs for the present beneficiaries in most of the proposals that are in his bill, as well as what you are discussing.

It will impact. You can't cut costs without having impact on the beneficiaries.

I can't say that the Secretary said it because I can't find the letter, but it is all over the Congressional Record that we are going to cut costs without impacting the beneficiaries, without having any impact on beneficiaries at all.

Of course, that is a little inconsistent, assuming that your recommendations follow the Latta recommendations. It is going to impact.

Ms. Davis. Mr. Rangel, I think that the assumptions are that if you have your largest outlays going to hospitals and physicians, you must begin to address those particular areas in order to curb the significant increase in those outlays.

It strikes me that we would be remiss in our duty if we were to say we should not take action to restrain the overall growth in either physician reimbursement or hospital reimbursement simply out of fear.

Mr. Rangel. I am not arguing with you, Doctor, I am just saying that when we vote to cut back benefits, we ought to say that we are cutting back benefits in order to save costs.

Just this mandating the employers have insurance past 65, that is a pretty rough burden for an old-timer to carry when he is trying to get a job. I would think especially when the law clearly says that they pay for their medicare benefits and they should be able to get it to 65, as an asset, could you walk into an employer saying I have my medical coverage and I am looking for work?

Under your proposal, the employer would have to cover him with private insurance and it means that they may take another look at whether or not they think it is a wise judgment to hire the person that comes in with medicare eligibility.

Now, I don't care how you cut it, that is cutting benefits. If the person is or has earned medicare coverage, you are mandating that the employer give private coverage and pay for it.

I am not saying I disagree with you, I am just saying that you just can't cut the programs and say the beneficiaries are not going to be hurt, especially in an election year.

Ms. Davis. We see that the working aged proposal will eliminate unwarranted subsidies to the private employers.

Mr. Rangel. Subsidies?

Ms. Davis. Yes.

Mr. Rangel. I am talking about the beneficiary, not the employer. The beneficiary comes in with coverage, it is no subsidy to him, right? He is 65. That is a right. That is earned.

Ms. Davis. Under the proposal for working aged, it is true that medicare would become the secondary payor to private health insurance, but I would like to—may I finish my statement, Mr. Rangel?

Mr. Rangel. Does that belong to the recipient now, is that something they have, they have coverage under medicare?

Ms. Davis. They would still have coverage under medicare. What we are suggesting is that medicare become secondary to the private health insurance plan. Right now we feel that the private health insurance plan has the advantage because the plan is experience rated.

Mr. Rangel. Just tell me that that proposal doesn't cut the benefits of the medicare recipient now by mandating that employers cover them in a private insurance package and then your statement would be consistent with Latta's floor statement.

If you are saying that that doesn't impact the oldtimer trying to get a job——

Ms. Davis. It does not cut medicare eligibility at all. What it simply indicates——

Mr. Rangel. I am asking whether it impacts on the old-timer's ability to get a job?

Ms. Davis. Roughly only one-quarter of 1 percent of the working population are over the age of 65 and we do not believe that the employers would take action to discriminate against the over-65 in this particular area.

The Age Discrimination in Employment Act speaks to that.

Mr. Rangel. So your answer is that it really doesn't impact on the beneficiaries at all?

Ms. Davis. Let me also discuss this in terms of the value of the medicare coverage component. We found if an individual pays into the hospital insurance trust fund from the beginning—from 1966—and retires now, they would have paid in—assuming they paid the maximum—approximately $3,000.

The present value of the contributions of that person over his working life would be approximately four times what he paid in. In other words, the benefits he would accrue would be in real terms four times what he had paid into that fund. If the individual has a spouse, they will accrue benefits roughly equal to eight times what they have paid in.

So I do not believe that there has been a diminution of that particular area.

Mr. Rangel. Thank you, Doctor.

Chairman Jacobs. Mr. Gradison.

Mr. Gradison. Thank you, Mr. Chairman.

Dr. Davis, I want to thank you for your valuable testimony. It certainly directly challenges the argument made earlier this morning that there are no ways in which to save money in this program without adversely affecting the beneficiaries of the program.

Certainly you gave us almost a dozen specific ideas to look over for our review with that goal in mind of saving money, but protecting those who are intended to be served by the medicare program.

Dr. Davis, I would like to look a little further ahead with you and see what your thinking is on the subject of prospective payment systems.

I understand you have a task force at work examining this. I wonder if you could give us any idea of what the status of that study is and what the timetable might be for making recommendations to the Congress?

Ms. Davis. Yes. The task force has been at work for the last several months. We have been examining a variety of alternatives. We have in the past funded a number of research demonstration programs and we have also taken the opportunity to study those particular initiatives in the various States.

Briefly, those initiatives encompass such areas as looking at the formula methodologies such as the rate of increase control, peer grouping, or schedule of individual case rates.

Those particular studies come from New York, Georgia, and New Jersey. In addition to that, we have looked at budget review and negotiated rates such as Rhode Island.

We have also considered options such as capitation, competitive bidding and fee schedules or indemnity plans.

While a number of these have now been discarded, we are in the final stages of making recommendations to the secretary relative to the prospective payment plan that we believe should be implemented.

I anticipate that we will meet our target date of making a report to Congress by the end of July.

I would also like to point out that one cannot just implement a prospective payment plan overnight. One does need time to phase that in. It would be a significant adjustment, I believe, to hospitals in terms of the way that accounting principles are done, and also in terms of regulatory activities.

Mr. GRADISON. Would you anticipate, Dr. Davis, that there would be a choice among plans which might be made by, say, hospitals or other providers? Or is your objective to come up with a single plan for nationwide application?

Or can you say at this point?

Ms. DAVIS. I really couldn't say at this time, Mr. Gradison. We have considered both, but if you leave it open to multiple options, it is clear you have difficulties in terms of administration. You would be subjecting the intermediaries to a wide variety of plans to implement.

I think one of the things we are clearly looking for in our criteria is simplicity in administration and implementation.

We are also looking toward reducing the requirements in terms of reporting burdens. Right now, we recognize that hospital cost reports are the fifth-most-burdensome report required by the Federal Government, requiring some 3,000 hours per facility to file. We are looking at ways we can significantly reduce reporting burdens. We are mindful of the fact that once we move to a prospective payment system, we can significantly reduce our regulatory burden because there are many regulations that currently apply only because we have a cost-based reimbursement system.

Third, we are trying to find a system that will reward efficient hospitals by allowing them to keep the funds beyond a particular figure, so if they are efficient in meeting the goal, then they have some rewards for that efficiency.

Finally, we are looking for something which is predictable in terms of Federal outlays as well as for the various hospitals.

Mr. GRADISON. Thank you very much. I know there is growing support here and around the country for some type of plan. It is encouraging to know that recommendations of your task force, as I understand it, might be completed and sent on to the Secretary next month, is that correct?

Ms. DAVIS. Yes.

Mr. GRADISON. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

Ms. Davis, you heard Congressman Gephardt talk about some of the areas that he felt that we should take a look at. One that he mentioned was the $25 billion that presently is expended through a tax expenditure, a tax credit for employer-employee health insurance.

I did not see anything in your testimony about it. I may have overlooked it. I wonder, have you taken a position on that?

Ms. Davis. I did not comment on the competition proposal in my testimony. The competition proposal is under separate review and, as Mr. Gradison mentioned earlier, it has been delayed.

Discussions are going on at the White House now. It was delayed because of the necessity for facing short-term, interim solutions for the budget this year.

Mr. Anthony. He also mentioned exclusion from taxation of employer health insurance payments.

I think that is the one he mentioned that had gone to $25 billion. Did you hear him mention that?

Ms. Davis. No, I didn't.

Mr. Anthony. Ms. Feinstein is shaking her head.

Ms. Davis. Sir, I can't hear you , that is my problem, really.

Mr. Anthony. Sorry. Congressman Gephardt was talking about the $25 billion tax expenditure through the Treasury—the tax system regarding employer tax deductions for insurance or health plans.

I didn't see anything on this in your testimony. I wonder if you have taken a position on it?

Ms. Davis. No, as I indicated earlier, the administration would be dealing with that issue one way or another in its competition bill.

So I did not address it here.

Mr. Anthony. So you would then clean that up by putting it in the total package of your competition bill?

When would the subcommittee likely have some definitive position on that, or articulation of the contents of the competition bill?

Do you think we would have it in time for us—when we go into the markup—to try to find the savings that might be required as a result of a budget, if a budget is passed?

Ms. Davis. It would be difficult for me to comment on how soon the competition bill would be reaching Congress. It has been delayed, as I indicated. There have been a number of discussions between the Secretary and the White House in terms of some of the areas in the bill.

There are some complex areas still to be addressed. However, those discussions had to be delayed somewhat because of the focus on this year's budget.

Mr. Anthony. Unfortunately, we have delayed a lot of things because of the budget.

Some people have also suggested that we tax Federal employees, HI tax. I didn't see anything in your testimony on that.

Have you taken a position on that? Are you for or against it?

Ms. Davis. Yes, we have taken a position on that. We believe that the HI tax should be imposed on Federal employees and they should be covered under medicare. I have spoken to this committee before on this. Since 60 to 80 percent of Federal employees are covered for part A of medicare at the time that they retire by having worked for 40 quarters outside the Federal Government. It would be only prudent for them to pay the HI tax during their Federal employment.

Mr. Anthony. Tell me, in that proposal where would there be cost savings? In other words, when we add up reconciliation figures, can we mark down that we have made some cost savings, assuming this one is passed?

Ms. Davis. I believe there is about $619 million in cost savings attributed to that area. It is a revenue producer for the trust fund.

Mr. Anthony. You hit the key word when you said it was a "revenue producer." What bothers me is do you think we will be able to count this as a savings since it is a revenue producer, based on our complicated method of reconciliation instructions and the way we have to count savings?

Ms. Davis. It would really depend on what accounting system one was using and I can't comment further on that issue. I think that from our point of view, we are concerned about the outlays from and income to the medicare trust fund.

If one has more revenue coming into the hospital insurance trust fund, then that helps to protect the financial integrity of the fund

Mr. Anthony. I am not arguing with that. I am arguing in-house procedural problems that we have in that if we——

Ms. Davis. I like to stay out of those.

Mr. Anthony. Can we claim credit for that savings and go to the House floor and say that we have met our task? Or are we going to have to pass that as revenue and find someplace else to make the cost savings since it is not a savings in medicare, but is actually a revenue producer?

That, versus what Mr. Gephardt talked about, and as I understand it, would very likely trigger some savings in health care costs, at the same time it provides revenues. Here we are looking at revenues and not savings.

Ms. Davis. I can't comment on your accounting procedures. I am not familiar with them.

Mr. Anthony. I don't want to belabor the point. You see the predicament we may have ourselves in?

Ms. Davis. Yes.

Mr. Anthony. That is a fairly substantial item, $600-plus million. It would make it easier for this one member not to have to make cuts on the poor and elderly and then go back home and campaign about it.

Just a couple of other questions, in-house type request things.

My staff has made me aware that since May of last year, you have a Texas Blue Cross/Blue Shield plan which uses some computer processing that you have had some problems with, and that either the contract contained, or the contract between the agencies and that party had a penalty clause attached to it.

I wonder if we are in the process of collecting the penalties? Has the penalty been waived or are they not in violation? Or do we need to get answers to that later on?

Ms. Davis. We would have to get that answer for the record, Mr. Anthony.

Mr. Anthony. I would welcome that.

Ms. Davis. I am familiar with the case, but I would rather not comment because I am not clear on the penalty aspects.

Mr. Anthony. It is a little far afield from here, but, yet, it is significant in the sense that if we are going to clean up some of our management procedures, we are going to have to rely upon computers.

If we rely upon computers, we have to use reliable data systems. If we are going to rely upon reliable data systems, we must have penalty provisions in the contract to whip them into shape. We must be sure we have that in place.

Ms. DAVIS. I think your point is well-taken. We have taken penalties against certain contractors for specific actions.

Mr. ANTHONY. We look forward to working with you. I again strongly urge that, at your earliest convenience, you get the specific language to us.

Our subcommittee has a task that I don't think any of us relish undertaking in the next few short weeks.

I yield back, Mr. Chairman.

Chairman JACOBS. Mr. Anthony, thank you.

Dr. Davis, the staff has prepared some questions, most of the balance of which I would like to submit to you in writing for future response, not too far in the future, I hope.

I should like to propound two of them now for the record.

[The information follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES,
HEALTH CARE FINANCING ADMINISTRATION,
Washington, D.C., July 22, 1982.

Hon. ANDY JACOBS, Jr.,
Chairman, Subcommittee on Health, Committee on Ways and Means,
U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I enclose answers to the additional questions you submitted to me as follow-up to the June 15 subcommittee hearing to discuss proposed fiscal year 1983 medicare program budget cuts. I hope these will be helpful to you as congressional consideration of the fiscal year 1983 budget continues.

Sincerely yours,

CAROLYNE K. DAVIS, PH. D., *Administrator.*

Enclosure.

Question 1. As GAO has discussed, several of the provisions enacted in the 1980 and 1981 Budget Reconciliation Bills have yet to be implemented. The provisions that have not been implemented tend to be administratively complex and usually affect reimbursement, such as the medicare secondary payor provisions. In light of this, how realistic is it to think that extensive revisions of Section 223 regulations can be made by October 1, 1982?

Answer. An October 1, 1982 effective date is feasible. Whether it is a realistic date depends upon the timing and specificity of the Congressional mandate.

Provisions in previous Reconciliation bills often required coordinated resolution of new eligibility, coverage, reimbursement, and administrative issues. In contrast, a proposal to extend Section 223 limits to total operating costs could build logically on reimbursement policy and administrative procedures currently in place. After six years of research and policy development, HCFA has developed a prototype system for total cost per case limits. If the existing prototype system were legislated to be effective October 1, 1982, Congress could exercise wide latitude in major policy decisions (e.g., at what percent of the group mean the limit would be set, and whether hold harmless and inflation allowances would be included) that determine the budget savings and the tolerance levels for inefficiency.

Separate consideration must always be given to the logistics of implementation even where the policy is clear. The Department has adopted the public participation procedures of the Administrative Procedures Act. Under these procedures major policy changes are proposed and open to public comment before being issued in final form. The Paperwork Burden Reduction Act requires substantial clearance procedures that affect changes in the cost reporting forms necessary to administer Section 223 total cost limits. Finally, the intermediaries and the hospitals would require some advance notification of new limits.

Question 2. In your testimony you mention a number of proposals which would reduce medicare outlays. What total do they add up to? As you know, we are being asked to find much larger savings than the $2.5 billion for fiscal year 1983 that the Administration budget originally assumed.

Answer. In my testimony, I discussed a number of the Administration's proposals to reduce Medicare outlays. We believe that our number one priority in the area of provider reimbursement reform should be to reduce the rate of increase in hospital costs. Also, because Medicare outlays for physician services have risen at a rate of 18 percent per year, we must direct much of our effort to reducing that rate of increase. The legislative and regulatory proposals I specifically mentioned in my testimony would result in Federal savings of $1.466 billion in fiscal year 1983.

In addition, Secretary Schweiker recently transmitted the proposed Health Care Financing Amendments of 1982 to the Congress. The proposed amendments contain a number of proposals which I did not discuss specifically in my testimony. These proposals are intended to ensure that the Medicare and Medicaid programs are carried out in a cost-effective manner. In that regard, our proposed legislation would revise coverage, benefits, and cost-sharing arrangements under Medicare and Medicaid in a manner that would reduce unnecessary utilization. Second, our proposals would encourage cost consciousness and efficient operation among individuals and institutions furnishing services under Medicare and Medicaid. and, finally, we propose enactment of administrative changes that would improve and enhance the operation of Medicare and Medicaid. We estimate that enactment of the proposed Health Care Financing Amendments of 1982 would result in Federal savings of $4.088 billion in fiscal year 1983, rising to $7.392 billion by fiscal year 1987.

Question 3. The Administration's budget for fiscal year 1983 proposed to maintain the medicare adminstrative budget at its current level. Considering inflation, the administrative budget in real dollars has probably decreased since 1980. The GAO has said that increasing the funding allocated to provider audits will result in significant short term savings, as much as $7 for each $1 spent. Why has the Administration been so opposed to providing additional funds for this function when the return is so substantial?

Answer. The fiscal year 1983 contractor budget was prepared with the view that increased efficiencies and cost savings would allow effective program administration within a stable budget. HCFA has initiated a Medicare Administrative Reform Initiative (MARI) to identify areas for reducing administrative costs, such as elimination of unnecessary Federal requirements, greater use of a uniform bill, and development of systems to streamline claims processing. As efficiencies are attained in administrative functions, resources will be released which will enable the contractors to expand their auditing activity. In this connection, HCFA is also developing methods to identify those providers for which large audit recoveries are most likely. Audits can then be focused on these providers.

Question 4. The Administration has a proposal called a private sector utilization review initiative which will, apparently, save over $300 million in fiscal year 1983. Yet the Administration's budget for fiscal year 1983 proposes to maintain the administrative budget at its current level—how do you think the medicare contractors will be able to carry out their expanded utilization review function without additional funds? Contractors are being instructed, even this fiscal year, to cut back their current functions because of limited funds. It seems unrealistic to assume such a large savings from new activities without providing funding for administrative costs. Perhaps you could elaborate on the specifics of the proposal.

Answer. The Medicare contractors have historically realized a very positive productivity gain through normal economies of scale and investments in upgrading claims processing systems. This annual productivity gain is responsible for keeping the annual rate of growth at a level below the combination of annual workload and inflation increases.

As a result of this productivity gain, HCFA has been able to maintain funding for its Payment Safeguards activities (i.e., medical utilization review and auditing) in a reasonable proportion to its primary mission of processing bills and claims. In fiscal year 1983, some direct HCFA assistance to the medical utilization review activity will be targeted on encouraging and complementing greater private sector involvement through various interest groups or coalitions.

These groups or coalitions have incentives of their own to develop and implement measures that will control the rate of escalation in providing medical care. These measures will impact both the private and public underwriting of health care insurance. Examples include coalitions lobbying State legislatures for cost control laws, business group monitoring of hospital use of employees, encouraging competition in large urban settings, establishing second-opinion panels for employees requiring surgery, channelling insured employees to hospitals and physicians who accept volume discounts, and encouraging cheaper delivery modes such as outpatient services.

It should also be remembered that medical utilization review bodies existed prior to PSROs and even when PSROs came on line, most hospitals maintained certain in-house medical utilization review (MUR) activities. In other words, an infrastructure exists, and this current emphasis on MUR both by HCFA and the private sector coalitions will not be a completely new effort.

Question 5. Since May of last year, Texas Blue Cross and Blue Shield has used a combined Part A and Part B computer processing system. Electronic Data Systems Federal was selected as subcontractor to implement the new integrated Medicare Part A and Part B automated claims processing system. There have, as you know, been significant delays and errors in claims processing, and according to a recent GAO report, the EDSF system, even as recently as February, 1982, was not fully operational. A clause in the contract requires a $15,000 per day penalty to be assessed against EDSF until the system is fully operational. What is the status of the fines—have fines been imposed? Is the claims processing system now fully operational?

Answer. The determination of the amount of the reduction to be imposed on EDSF has been under negotiation by Blue Cross/Blue Shield of Texas (BCBST) and EDSF since February. On June 15, 1982, the parties reached an agreement establishing this amount as over $2 million. This agreement has been approved by HCFA and the balance of the amount will be collected in cash installments and through future services to be furnished by EDSF. (Some of the amount has already been recovered from EDSF through services it furnished in addition to those required by the original letter of agreement with BCBST.)

The EDSF claims processing system is now fully operational and its performance has significantly improved in recent months. HCFA will continue to closely monitor the efforts of BCBST and EDSF to improve further the quality and timeliness of the system.

Chairman JACOBS. Has the administration a position on H.R. 3399, the HMO legislation approved by the Commerce Committee?

Ms. DAVIS. Mr. Chairman, could you tell me the bill again?

Chairman JACOBS. Yes, H.R. 3399. It has been approved by the House Energy and Commerce Committee, relating to reimbursement of health maintenance organizations.

Ms. DAVIS. Let me just check.

I am sorry, we will have to submit that for the record. I am not familiar with that.

Chairman JACOBS. That is the 95-percent reimbursement.

Ms. DAVIS. Yes; I know what you mean, Mr. Chairman.

Chairman JACOBS. You are not sure what the administration's position is? I think we would very much like to know about that because it is sliding along.

Some people say it might save you some money. You might look into that.

The other question is, can you say offhand how much the Latta budget, which was approved by the House, reduces your own administrative budget?

Ms. DAVIS. No, sir, I really couldn't say because I have not seen that in detail.

Chairman JACOBS. You would be right on the top.

Ms. DAVIS. From the beginning of my tenure as Administrator until now, we have reduced the work force by 12 percent, so we have taken a substantial cut.

Chairman JACOBS. The work force or payroll, did you say?

Ms. DAVIS. The work force, per se. I am down from——

Chairman JACOBS. Is it down in money or just down in people?

Ms. DAVIS. Both have gone down.

Chairman JACOBS. Which more than the other?

Ms. DAVIS. Due to inflation for nonpersonnel costs and pay raises, the work force has gone down more than the money. When you adjust for inflation and pay raises, both have gone down about the same.

Chairman JACOBS. The specific question is what Latta does in terms of the difference between what my cousin costs in 1982 and 1983.

Ms. DAVIS. I don't have that detail, Mr. Chairman.

Chairman JACOBS. OK, we thank you very much for appearing.

The next witness represents the Congressional Budget Office, Dr. Paul Ginsburg, chief, Income Security and Health Unit.

Mr. Ginsburg, you know the rules of the New York State Athletic Commission. Start it up.

STATEMENT OF PAUL B. GINSBURG, DEPUTY ASSISTANT DIRECTOR FOR INCOME SECURITY AND HEALTH, HUMAN RESOURCES AND COMMUNITY DEVELOPMENT DIVISION, CONGRESSIONAL BUDGET OFFICE

Mr. GINSBURG. I am Paul B. Ginsburg, deputy assistant director for Income Security and Health, Human Resources and Community Development Division, Congressional Budget Office.

Mr. Chairman, in the interests of time, I will omit parts of my statement, which I will submit for the record. I will also submit for the record an analysis of the American Hospital Association's proposal to modify the hospital reimbursement by medicare, which was prepared at your request.

Under the first concurrent budget resolution for 1983, that was passed by the House last week, significant reductions in spending for medicare would be required in the next 3 fiscal years.

Since comparable reductions would be required under the version passed by the Senate, this committee will soon likely be considering program changes to meet a budget reduction target.

My testimony today will discuss some of the broad options that the committee has in meeting these targets.

Its major point is that given the magnitude of the savings called for, a reduction in the underlying growth of medical care costs is essential if substantial reductions are to be avoided in the degree of financial protection that medicare provides the aged and disabled.

The spending cuts called for in the budget resolution respond to a bleak, long-term outlook. Despite a projection of moderate economic recovery, the CBO forecasts increasing deficits if current policies are unchanged.

By 1987, without changes in tax laws or spending programs, the deficit is projected to reach $250 billion, and could be much higher if the economy's performance is worse.

With medicare accounting for 9 percent of Federal spending by that year, pressures to restrain growth in outlays in that program are likely to continue.

Even in the absence of general budget pressure to curb medicare spending, declining balances in the Federal hospital insurance [HI] trust fund later in this decade will focus attention on changes in medicare.

Under current policies, the HI trust fund is likely to become exhausted by the late 1980's. The basic problem is that spending for medicare is growing much faster than the earnings that are taxed to pay for it.

Rapid increases projected for medicare spending reflect two factors—the aging of the population and the rising costs of medical care. Not only is the proportion of the population aged 65 and over increasing, but the average age for this group is increasing as well, and medical costs for the elderly rise sharply with age.

Since medicare pays for medical services that are purchased in the private sector, rising medical care costs increase medicare outlays automatically.

After adjusting for general inflation, per capita medical care spending among the general population increased by 124 percent between 1965 and 1980—or at an annual rate of 6 percent in real terms—and this trend is projected to continue.

Since the aging of the population cannot be changed, controlling growth in medicare spending without cutting benefits substantially requires taking steps to control medical care cost increases.

Two major options to contain costs are available—increased cost-sharing by beneficiaries, and changes in the manner in which hospitals and physicians are reimbursed for services by medicare and other third-party payers.

Increased cost-sharing—that is, an increase in the proportion of charges paid by medicare beneficiaries—would tend to reduce the use of medical services and put downward pressure on prices.

There would, of course, be some loss of financial protection against unavoidable medical expenses.

Critics also contend that it would cause patients to forgo important medical services, especially patients with low incomes; however, varying the degree of cost-sharing with recipients' incomes would mitigate such effects.

If increased cost-sharing is to be pursued as a cost-containment policy, three issues must be addressed. The first concerns private supplemental coverage.

Since over half of medicare beneficiaries are covered by private supplemental plans—often referred to as "medigap" policies—and another seventh receive medicaid, effective cost-sharing would require that some beneficiaries drop these policies.

One way to reduce reliance on these policies would be to reduce the current large implicit subsidy provided by medicare to the purchasers of private supplemental plans.

These plans reimburse their beneficiaries for medicare's deductibles and coinsurance, and thus tend to increase the use of medicare services.

Since medicare pays the bulk of the bills for these additional services, the supplemental coverage works to increase Federal outlays. Taxing the premiums of supplemental policies at a rate of about 35 percent would cause the policyholders to pay the full costs of their private coverage, and reduce fiscal year 1983 budget deficits by $2.5 billion.

The second issue concerns giving people incentives through cost-sharing to choose lower-cost hospitals. Under current law, medicare requires the beneficiary to pay the same amount, no matter which institution is used, so that there is no incentive to choose a lower cost hospital.

Having the deductable and coinsurance depend on a hospital's allowable costs per day, possibly adjusted for local wage rates and the hospital's case mix, would increase competition among hospitals to keep costs down, and result in more cost containment for a given amount of cost-sharing.

The third issue is whether the degree of additional cost-sharing in medicare should vary with the recipients' incomes. If such variation were restricted to hospital services and a relatively crude test employed, administration would not be too difficult.

For example, 10 percent coinsurance could be required for the second through the 30th hospital days in an episode of illness, but persons with incomes below a certain level could apply to have this coinsurance waived.

Some favor this approach as a way to make greater use of cost-sharing without harming the needy, but others object to moving medicare away from social insurance principles.

Another approach to containing costs would be to change the way medicare reimburses hospitals and physicians so as to alter the incentives faced by these providers.

Opportunities for cost containment are the greatest in hospital reimbursement because the existing system is so devoid of favorable incentives.

Medicare reimburses hospitals on the basis of incurred costs, so that they automatically receive reimbursement increases whenever their costs increase.

Another reason is that medicare and medicaid patients account for a particularly large proportion of hospital revenues.

Paying hospitals on the basis of prospective rates, where the payment is set in advance and not adjusted to reflect incurred costs, would change hospital incentives, inducing them to contain costs.

Since those hospitals that are able to reduce their costs would not suffer financially, and indeed could gain from it, prospective payment offers the possibility of large savings in medicare outlays over time.

Prospective rates could reasonably be set to increase 2 percentage points per year more slowly than would medicare reimbursements under current policies.

In this case, savings would amount to $760 million in 1983, growing to $3 billion in 1985, and $6 billion in 1987. Prospective payment could increase Federal outlays, however, if the rates were inadvertently set too high.

Prospective payment would involve some difficult technical issues, but a number of States and private organizations have pursued it and succeeded in containing costs.

The principal difficulty stems from the need to set a different rate for each hospital, one that reflects the mix of patients treated and local factors that affect costs.

Nevertheless, from 1976 to 1980, community hospital expenditures per capita in the six States with mature prospective reimbursement systems increased at an annual rate of 10 percent per year, compared with 14 percent in the rest of the country.

A negative aspect of prospective rates for some is that, even though it works through incentives, it is a regulatory system.

The agency setting the rates could set them too high or too low, and the rates might inadequately reflect legitimate cost differences among hospitals.

In addition, the conflict between the well-insured patient demanding the best possible care and the hospital under pressure from its payers to use services more judiciously could lead to some shifting of service delivery outside of the sector where rates are set prospectively.

A partial step in the direction of prospective payment is to place limits on reimbursements of incurred costs. For those hospitals whose reimbursements would have been higher than the limits, incentives to contain costs would be established.

Medicare has some experience with reimbursement limits, in that it limits payments for routine costs under section 223 of the 1972 amendments to the Social Security Act.

Reimbursement limits have the advantage of generating greater short-term savings because reimbursement reductions to some hospitals would not be partially offset by reimbursement increases to others.

On the other hand, reimbursement limits would provide weaker incentives to contain costs than prospective rates, so their long-term potential for budget savings would be less.

Prospective rates would change the incentives for all hospitals rather than only those expected to exceed the limits, and rewards for cost reduction would not stop once the reimbursement limit was reached.

My statement includes a discussion of setting rates or limits and I would skip that in the interests of time.

Perhaps the most important issue to be faced by the Congress when it considers changes in hospital reimbursement is whether to limit them to medicare (and indirectly, medicaid), or to apply them to all payers.

A medicare-only system certainly intrudes less into the private sector, reflecting only prudent purchasing on behalf of the Government, and is simpler administratively.

On the other hand, it would result in less cost containment and pose risks to beneficiaries' access to hospital care.

Less cost containment would be achieved by a medicare-only system because of the ability of hospitals to make up some of the reimbursement reduction by raising charges to private patients, most of whom are well-insured.

Such "cost-sharing" would be limited, however, because the large proportion of hospital revenues accounted for by medicare and medicaid patients—about 45 percent over all community hospitals—would preclude the shifting of all of the reimbursement reduction and thus leave some incentives to reduce costs.

Chairman Jacobs. Would you mind suspending for a few minutes, Mr. Ginsburg—13 to be exact—we have a series of votes taking place on the floor and I believe we can be back about then.

Without objection, we will stand in recess for about that period of time.

[Recess.]

Chairman Jacobs. Sorry for the inconvenience, Doctor. If you will continue where you were interrupted, it will be great.

Mr. GINSBURG. Maybe I will back up a few words.

I mentioned the medicare only system would result in less cost containment, and imposes risks to beneficiary hospital care.

Less cost containment would be achieved by a medicare-only system because of the ability of hospitals to make up some of the reimbursement reduction by raising charges to private patients, most of whom are well insured. Such "cost shifting" would be limited, however, because the large proportion of hospital revenues accounted for by medicare and medicaid patients—about 45 percent over all community hospitals—would preclude the shifting of all of the reimbursement reduction and thus leave some incentives to reduce costs.

Within a medicare-only system, prospective rates would probably result in less cost shifting than reimbursement limits, because they would offer hospitals greater rewards for containing costs.

Reimbursement reductions applying only to medicare and medicaid could reduce beneficiaries' access in two ways. First, some hospitals might turn away public patients because private patients would be willing to pay more. Second, some hospitals with predominantly medicare and medicaid caseloads would lose out in the competition for capital financing to hospitals with relatively more favorable financial prospects.

PHYSICIAN REIMBURSEMENT

Reforms in physician reimbursement could yield significant budget savings, but an important part would come at the expense of beneficiaries rather than physicians.

Since physicians are permitted to collect from patients the amounts of fees that exceed what medicare judges to be reasonable—which they do for roughly half of claims—further reductions in reimbursement might often be passed on to the beneficiaries.

Requiring physicians to accept medicare reasonable charges as payment in full might be a prerequisite for using reimbursement policy to control the costs of physicians' services, although some are concerned about the reduction in access to care that might result from such an option.

One possible direction for changing physician reimbursement policy would involve concentrating any reductions on services for which reimbursement is relatively generous. Some studies have indicated that physician time spent performing surgery and diagnostic procedures is much more highly remunerated than time spent examining and counseling patients. Similarly, time spent with patients in the hospital is reimbursed at higher rates than time spent in the office.

Such differences in relative fees, which are automatically reflected in medicare's reimbursement system, probably influence the mix of services and the setting in which they are performed. Concentrating reimbursement reductions on those services compensated most highly might do more to reduce total costs than a uniform reduction.

In conclusion, making long-term reductions in medicare outlays without cutting substantially into in benefits will require control of the growth in overall medical care costs. If cost sharing is to be used to contain costs, public policy toward private supplemental coverage will have to be reconsidered. In addition, changes in hospital reimbursement policies, particularly the use of prospective rates, could potentially reduce costs significantly. A key issue here is whether to extend the policy changes to payers other than medicare and medicaid.

In considering options for fiscal year 1983, an important criterion might be whether they would make it easier to pursue cost containment in the future. For example, expanded section 223 limits, while not capable of affecting many hospitals' incentives initially, might make a sophisticated prospective payment system—or an indemnity benefit system, for that matter—more feasible in the future.

[The prepared statement and analysis follows:]

STATEMENT OF PAUL B. GINSBURG, DEPUTY ASSISTANT DIRECTOR FOR INCOME SECURITY AND HEALTH, HUMAN RESOURCES AND COMMUNITY DEVELOPMENT DIVISION, CONGRESSIONAL BUDGET OFFICE

Under the First Concurrent Resolution on the Budget for 1983 (H. Con. Res. 352), passed by the House last week, significant reductions in spending for Medicare would be required in fiscal years 1983, 1984, and 1985. Since comparable reductions would also be required under the version passed be the Senate, this Committee soon will likely be considering program changes to meet a budget reduction target.

My testimony today will discuss some of the broad options the Committee has in meeting these targets. Its major point is that, given the magnitude of the savings called for, a reduction in the underlying growth in medical care costs is essential if substantial reducions are to be avoided in the degree of financial protection that Medicare provides to the aged and disabled.

BACKGROUND

The spending cuts called for in the budget resolutions respond to a bleak long-term budget outlook. Despite a projection of moderate economic recovery, the CBO forecasts increasing deficits if current policies are unchanged. By 1987, without changes in tax laws or spending programs, the deficit is projected to reach $250 billion, and could be much higher if the economy's performance is worse. With Medicare accounting for 9 percent of federal spending by that year, pressures to restrain growth in outlays in that program are likely to continue.

Even in the absence of general budget pressure to curb Medicare spending, declining balances in the Federal Hospital Insurance (HI) Trust Fund later in this decade will focus attention on changes in Medicare. Under current policies, the HI Trust Fund is likely to become exhausted by the late 1980s. The basic problem is that spending for Medicare is growing much faster than the earnings that are taxed to pay for it.

Rapid increases projected for Medicare spending reflect two factors—the aging of the population and the rising costs of medical care. Not only is the proportion of the population aged 65 and over increasing, but the average age for this group is increasing as well, and medical costs for the elderly rise sharply with age.

Since Medicare pays for medical services that are purchased in the private sector, rising medical care costs increase Medicare outlays automatically. After adjusting for general inflation, per capita medical care spending among the general population increased by 124 percent between 1965 and 1980—or at an annual rate of 6 percent in real terms—and this trend is projected to continue.

Since the aging of the population cannot be changed, controlling growth in medicare spending without cutting benefits substantially requires taking steps to control medical care cost increases. Two major options to contain costs are available—increased cost-sharing by beneficiaries, and changes in the manner in which hospitals and physicians are reimbursed for services by Medicare and other third-party payers.

INCREASED COST SHARING

Increased cost sharing—that is, an increase in the proportion of charges paid by Medicare beneficiaries—would tend to reduce the use of medical services and put downward pressure on prices. There would, of course, be some loss of financial protection against unavoidable medical expenses. Critics also contend that it would cause patients to forgo important medical services, especially patients with low incomes: however, varying the degree of cost sharing with recipients' incomes would mitigate such an effect.

PRIVATE SUPPLEMENTAL INSURANCE

If increased cost sharing is to be pursued as a cost containment policy, three issues must be addressed. The first concerns private supplemental coverage. Since over half of Medicare beneficiaries are covered by private supplemental plans (often referred to as "Medigap" policies) and another seventh receive Medicaid, effective cost sharing would require that some beneficiaries drop these policies.

One way to reduce reliance on these policies would be to reduce the current large implicit subsidy provided by Medicare to the purchasers of private supplemental plans. These plans reimburse their beneficiaries for Medicare's deductibles and coinsurance, and thus tend to increase the use of Medicare services. Since Medicare pays the bulk of the bills for these additional services, the supplemental coverage works to increase federal outlays. Taxing the premiums of supplemental policies at a rate of about 35 percent would cause the policyholders to pay the full costs of their private coverage, and reduce fiscal year 1983 budget deficits by $2.5 billion.

VARYING COST SHARING BY PROVIDER

The second issue concerns giving people incentives through cost sharing to choose lower-cost hospitals. Under current law, Medicare requires the beneficiary to pay the same amount no matter which institution is used, so that there is no incentive to choose a lower-cost hospital. Having the deductible and coinsurance depend on a hospital's allowable costs per day, possibly adjusted for local wage rates and the hospital's case mix, would increase competition among hospitals to keep costs down, and result in more cost containment for a given amount of cost sharing.

VARYING COST SHARING BY RECIPIENTS' INCOMES

The third issue is whether the degree of additional cost sharing in Medicare should vary with the recipients' incomes. If such variation were restricted to hospital services and a relatively crude test employed, administration would not be too difficult. For example, 10 percent coinsurance could be required for the second through thirtieth hospital days in an episode of illnesss, but persons with incomes below a certain level could apply to have this coinsurance waived. Some favor this approach as a way to make greater use of cost sharing without harming the needy, but others object to moving Medicare away from social insurance principles.

REIMBURSEMENT CHANGES

Another approach to containing costs would be to change the way Medicare reimburses hospitals and physicians so as to alter the incentives faced by these providers.

HOSPITAL REIMBURSEMENT

Opportunities for cost containment are the greatest in hospital reimbursement because the existing system is so devoid of favorable incentives. Medicare reimburses hospitals on the basis of incurred costs, so that they automatically receive reimbursement increases whenever their costs increase. Another reason is that Medicare and Medicaid patients account for a particularly large proportion of hospital revenues.

Prospective rates. Paying hospitals on the basis of prospective rates, where the payment is set in advance and not adjusted to reflect incurred costs, would change hospital incentives, inducing them to contain costs. Since those hospitals that are able to reduce their costs would not suffer financially, and indeed could gain from it, prospective payment offers the possibility of large savings in Medicare outlays over time. Prospective rates could reasonably be set to increase two percentage points per year more slowly than would Medicare reimbursements under current policies. In this case, savings would amount to $760 million in 1983, growing to $3 billion in 1985, and $6 billion in 1987. Prospective payment could increase federal outlays, however, if the rates were inadvertently set too high.

Prospective payment would involve some difficult technical issues, but a number of states and private organizations have pursued it and succeeded in containing costs. The principal difficulty stems from the need to set a different rate for each hospital, one that reflects the mix of patients treated and local factors that affect costs. Nevertheless, from 1976 to 1980, community hospital expenditures per capita in the six states with mature prospective reimbursement systems increased at an annual rate of 10 percent per year, compared with 14 percent in the rest of the country.

A negative aspect of prospective rates for some is that, even though it works through incentives, it is a regulatory system. The agency setting the rates could set them too high or too low, and the rates might inadequately reflect legitimate cost differences among hospitals. In addition, the conflict between the well-insured patient demanding the best possible care and the hospital under pressure from its payers to use services more judiciously could lead to some shifting of service delivery outside of the sector where rates are set prospectively.

Reimbursement limits. A partial step in the direction of prospective payment is to place limits on reimbursements of incurred costs. For those hospitals whose reimbursements would have been higher than the limits, incentives to contain costs would be established. Medicare has some experience with reimbursement limits, in that it limits payments for routine costs under Section 223 of the 1972 amendments to the Social Security Act.

Reimbursement limits have the advantage of generating greater short-term savings because reimbursement reductions to some hospitals would not be partially offset by reimbursement increases to others. On the other hand, reimbursement limits would provide weaker incentives to contain costs than prospective rates, so their long-term potential for budget savings would be less. Prospective rates would change the incentives for all hospitals rather than only those expecting to exceed the limits, and rewards for cost reduction would not stop once the reimbursement limit was reached.

Setting the rates or limits. Whether prospective rates or reimbursement limits were pursued, the method of setting them must be chosen. Essentially, hospitals could be compared with their peers, as in the "Section 223" methodology used today, or rates could be set according to Medicare reimbursements during a base period, as in the recent proposal by the American Hospital Association, or the two methods could be combined.

The advantage of peer comparisons is that penalties are directed only at those hospitals judged to be relatively inefficient. A disadvantage is that our technical ability to make the peer comparisons might not yet be commensurate with the task, so that inequities among hospitals could result.

Moreover, when used to set reimbursement limits, peer comparisons tend to change the incentives of smaller proportion of hospitals, thus limiting the potential for cost containment, compared with limits based on a past period. For example, only 25 percent of hospitals will be affected in 1982 by the recently tightened Section 223 limits. The potential for large budget savings is also reduced by peer comparison, since only a minority of hospitals would get lower reimbursements. In contrast, limits or rates based on prior reimbursements would spread the burden more evenly among hospitals, so that larger savings could be obtained.

Combining the two methods is feasible and has some advantages. For example, the Congress might extend the current Section 223 limits from their current coverage of routine costs to coverage of all operating costs. This would extend incentives to contain costs to ancillary services, where much of the recent increase in costs has taken place. But since techniques for adjusting for diagnostic mix are controversial and relatively untested at this point, expanded Section 223 limits might be set relatively high initially, The remainder of any budget savings goal could be achieved by either a prospective rate or a limit based on 1981 or 1982 reimbursements. As techniques to adjust for case mix differences improve with experience, more emphasis could be placed on peer comparisons.

Which payers should be included? Perhaps the most important issue to be faced by the Congress when it considers changes in hospital reimbursement is whether to limit them to Medicare (and indirectly Medicaid), or to apply them to all payers.[1] A Medicare-only system certainly intrudes less into the private sector, reflecting only prudent purchasing on behalf of the government, and is simple administratively. On the other hand, it would result in less cost containment and pose risks to beneficiaries' access to hospital care.

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[1] Under current law, Medicaid hospital reimbursements cannot exceed Medicare's, so in those states which have not implemented an alternative reimbursement method, Medicaid reimbursements would be affected by changes in Medicare.

Less cost containment would be achieved by a Medicare-only system because of the ability of hospitals to make up some of the reimbursement reduction by raising charges to private patients, most of whom are well insured. Such "cost shifting" would be limited, however, because the large proportion of hospital revenues accounted for by Medicare and Medicaid patients—about 45 percent over all community hospitals—would preclude the shifting of all of the reimbursement reduction and thus leave some incentives to reduce costs. Within a Medicare-only system, prospective rates would probably result in less cost shifting than reimbursement limits, because they would offer hospitals greater rewards for containing costs.

Reimbursement reductions applying only to Medicare and Medicaid could reduce beneficiaries' access in two ways. First, some hospitals might turn away public patients because private patients would be willing to pay more. Second, some hospitals with predominantly Medicare and Medicaid caseloads would lose out in the competition for capital financing to hospitals with relatively more favorable financial prospects.

PHYSICIAN REIMBURSEMENT

Reforms in physician reimbursement could yield significant budget savings, but an important part would come at the expense of beneficiaries rather than physicians. Spending by the Supplementary Medical Insurance (SMI) trust fund, much of which is for physician services, totalled $16.8 billion in fiscal year 1981, and has been growing rapidly. Since physicians are permitted to collect from patients the amounts of fees that exceed what Medicare judges to be reasonable—which they do for roughly half of claims—further reductions in reimbursement might often be passed on to the beneficiaries. Requiring physicians to accept Medicare reasonable charges as payment in full might be a prerequisite for using reimbursement policy to control the costs of physicians' services, although some are concerned about the reduction in access to care that might result.

One possible direction for changing physician reimbursement policy would involve concentrating any reductions on services for which reimbursement is relatively generous. Some studies have indicated that physician time spent performing surgery and diagnostic procedures is much more highly remunerated than time spent examining and counseling patients. Similarly, time spent with patients in the hospital is reimbursed at higher rates than time spent in the office. Such differences in relative fees, which are automatically reflected in Medicare's reimbursement system, probably influence the mix of services and the setting in which they are performed. Concentrating reimbursement reductions on those services compensated most highly might do more to reduce total costs than a uniform reduction.

CONCLUSION

Making long-term reductions in Medicare outlays without cutting substantially into in benefits will require control of the growth in overall medical care costs. If cost sharing is to be used to contain costs, public policy toward private supplemental coverage will have to be reconsidered. In addition, changes in hospital reimbursement policies, particularly the use of prospective rates, could potentially reduce costs significantly. A key issue here is whether to extend the policy changes to payers other than Medicare and Medicaid.

In considering options for fiscal year 1983, an important criterion might be whether they would make it easier to pursue cost containment in the future. For example, expanded Section 223 limits, while not capable of affecting many hospitals' incentives initially, might make a sophisticated prospective payment system (or an indemnity benefit system, for that matter) more feasible in the future.

An Analysis of the American Hospital Association's Proposal To Modify Medicare Hospital Reimbursement—June 1982

PREPARED BY THE STAFF OF THE HUMAN RESOURCES AND COMMUNITY DEVELOPMENT DIVISION CONGRESSIONAL BUDGET OFFICE

The American Hospital Association (AHA) has proposed a prospective, fixed-price system of reimbursement by Medicare for inpatient hospital service.[1] Under the proposal, Medicare outlays would decrease by about $320 million in fiscal year 1983, and $1.1 billion in 1984. These savings would be reduced by successful appeals and by shifts of some costs to outpatient departments, but the extent of these reductions cannot be estimated. The proposal could be modified to yield even greater savings, however. Savings might increase in 1985 and later years, although some of the provisions applicable after 1984 are too vague to permit a cost estimate.

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[1] The AHA proposal has been revised and clarified a number of times since its release on April 14, 1982. This analysis is based upon the most recent draft language available at this time, the version dated June 4, 1982.

THE PROPOSAL

Reimbursement rates under the proposal would be set in the following way. Each hospital's most recently reported cost per discharge, excluding payments for return on equity and any adjustments made under Section 223 routine cost limits, and inflated to fiscal year 1983 levels, would be the base payment. An 8.0 percent adjustment would be made to reflect increased hospital input prices in 1983. Beginning in fiscal year 1984, a private organization would determine an annual adjustment factor that would reflect hospital input price increases, plus one percentage point per year to reflect medical technology advances. The organization would be required to use the methodology currently used by the Health Care Financing Administration in constructing the National Hospital Input Price Index.

A further adjustment would also be made to allow reimbursement for capital costs from new projects. This would differ from current policy only in that capital costs associated with projects not approved by a state regulatory agency or required by a facility standards agency would be disallowed.

Each year, small rural hospitals would have the option of receiving payment under the current system or choosing to participate in the prospective system. The current Section 223 limits on routine costs would be maintained for hospitals choosing not to receive prospective payment.

Participating hospitals would choose whether to accept the Medicare rate as payment in full. Those not doing so would be able to charge beneficiaries the difference between actual charges and the Medicare payment, up to a limit that would be set at the lesser of $1,000 or the hospital's average percentage of charges not paid by Medicare in the base year. The latter limit would preserve the current Medicare discount of roughly 20 percent of charges incurred by beneficiaries.

A number of provisions would encourage hospitals to accept assignment—that is, to accept Medicare reimbursement as payment in full. Investor-owned hospitals would receive return-on-equity reimbursement only if they agreed to accept assignment. Nonprofit hospitals would receive a capital maintenance adjustment similar to the current return-on-equity only if they chose to accept assignment. Hospitals with relatively heavy Medicare and Medicaid patient loads—defined as generating over 50 percent of revenue—would also receive an additional reimbursement increase for choosing to accept assignment. Only hospitals accepting assignment would be reimbursed for bad debts not collected from beneficiaries.

Hospitals would be allowed to appeal their prospective rate on a number of grounds. These include changes in the mix of patients they serve, an increase in the number of beds, and inadequate capital reimbursement. The Provider Reimbursement Review Board would face several time constraints—requests for additional information from the hospital could be made only within 15 days after the appeal was filed, and if no decision was reached within 90 days, the decision would favor the hospital.

Although only inpatient hospital services are covered under the proposal, it does require that the Secretary of Health and Human Services submit a proposal for prospective payment of outpatient and emergency services early in the 98th Congress. No enactment date is proposed, however.

The Secretary of Health and Human Services (HHS) would be required to ensure that growth in aggregate Medicare admissions be held to 2 percent in fiscal year 1983. The mechanism with which to accomplish this outcome is not specified other than that it be utilized review. Payments to hospitals could not be reduced by this requirement except for reasons of the medical appropriateness of particular admissions.

Preadmission screening to determine the necessity of all Medicare admissions would be required under the proposal. The necessity of emergency admissions would be assessed within 48 hours of admission. Hospitals with approved utilization review programs would be reimbursed for the costs of this review. Other hospitals would have admissions reviewed by agencies approved by the Department, presumably fiscal intermediaries or Professional Standards Review Organizations.

After two years, the AHA proposal would allow hospitals in an area to elect a competitive process in which each hospital would propose a Medicare reimbursement rate, which would be reviewed for approval by Medicare. If a bid was not approved or negotiated, the hospital would receive the average of the area's approved reimbursement rates.

EFFECTS OF THE AHA PROPOSAL ON FEDERAL SPENDING

The AHA proposal would reduce Medicare outlays by $320 million in fiscal year 1983, and $1.1 billion in fiscal year 1984. (see Table 1). If the proposal described for 1983 and 1984 was maintained, savings would increase in the out-years. Because the competitive bidding process intended for 1985 is not clearly specified and has incentives that could lead to higher payments, out-year savings might not be achieved. Since the 1981 reconciliation act awarded states flexibility in making hospital payments under Medicaid, no Medicaid reimbursement changes are assumed by this proposal.[2]

TABLE 1. BUDGETARY EFFECTS OF VARIOUS PROVISIONS OF THE AHA PROPOSAL,[1] FISCAL YEARS 1983 and 1984

[In millions of dollars]

	Outlays	
	1983	1984
Prospective baseline	31,060	35,920
Nonparticipating hospitals [2]	1,300	1,520
Adjustments to the rate base:		
Section 223	270	60
Elimination of return-on-equity	−310	
Adjustments to the prospective rate:		
Price adjustment [3]	2,480	3,020
Admissions growth	1,060	1,190
Intensity factor		360
Capital costs pass-through [4]	360	410
Utilization review [5]		
Captial maintenance factor [6]	700	
Return-on-equity	230	
Volume adjustment [7]	70	10
Bad debts [8]		
Increase for nonparticipating hospitals	220	240
Total	37,440	42,730
Current policy	37,760	43,840
Difference	−320	−1,110
Percentage increase from previous year:		
Current policy	16.7	16.1
AHA proposal	15.7	14.1

[1] June 4, 1982, version.

[2] Of small rural hospitals, which account for about 8 percent of reimbursement, 50 percent are assumed to choose to participate in the prospective system.

[3] CBO forecasts an 8.4 percent increase in hospital input prices for fiscal year 1984.

[4] HCFA has estimated reimbursements for capital costs to be 7 percent of medicare payments.

[5] The current policy base includes payments for hospital-based utilization review. No increase in payments is assumed under the proposal's utilization review program.

[6] The AHA estimates a $24 billion equity base for community hospitals in 1980, up 10 percent from 1979. If the increase has been 10 percent a year, the base would be about $30.7 billion in 1983 for participating hospitals. The rate is the GNP deflator, which the CBO estimates is 7.3 percent in 1983 and 6.6 percent in 1984.

[7] The AHA estimates that 16.8 percent of payments are made to hospitals with a medicare and medicaid patient load between 50 and 65 percent, and 3.8 percent with a patient load over 65 percent. Under the proposal, the former hospitals would receive a 1 percent increase in their base, and the latter would receive a 1.5 percent increase. All these hospitals are assumed to participate in the prospective system and to accept assignment.

[8] Only hospitals accepting assignment would be reimbursed for bad debts under the proposal. The estimate assumes that most hospitals with significant bad debts under medicare would choose to accept assignment, and therefore would be virtually no change in bad debt payments from current policy.

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[2] In the past, Medicaid savings would have resulted from changes in Medicare hospital reimbursement. This estimate assumes that because states no longer have to use Medicare reimbursement as a basis for Medicaid payments, no savings from reduced hospital reimbursement by Medicaid need to be included. This assumption is currently being reconsidered in light of actual state responses to the new Medicaid provision.

These savings would be reduced by two factors that are difficult to quantify. First, savings could be offset if hospitals shifted costs to outpatient services, which would continue to be reimbursed on a cost basis under the proposal. In addition, if laboratory or radiology services were shifted from Part A to Part B payment—by leasing, for example—the hospital's Part B reimbursement would increase while the prospective base would not be lowered.

Second, the savings estimate does not include the effects of appeals. There is no way to estimate the extent to which savings would be reduced by appeals, but it could be significant given the broad grounds allowed and the fact that hospitals choosing to appeal would not risk receiving a lower rate. Each 1 percent increase in reimbursement resulting from these two factors would reduce 1983 federal savings by about $360 million, and savings in subsequent years by more.

ASSUMPTIONS

The estimate makes a number of assumptions as to how hospitals would respond to the proposed payment system. These involve the number of hospitals participating, the number of participating hospitals that would accept assignment, and the effect of the proposal on Medicare admissions.

Participation. Fifty percent of small rural hospitals are assumed to choose participation in the prospective system. The average rate of increase in Medicare costs for these hospitals is slightly lower than the average, so those with relatively low growth rates would benefit from a prospective rate based on the higher overall growth rate. Those hospitals with relatively high rates of growth would benefit from remaining in the current reimbursement system.

Assignment. Hospitals accounting for 90 percent of reimbursement to nonprofit hospitals and 75 percent of reimbursement to investor-owned hospitals are assumed to accept assignment, although the proportion would decline in later years. Most hospitals would find the payment incentives attractive, while the benefits of billing beneficiaries for unpaid charges would be limited by the requirements for preservation of the Medicare discount, the costs of collection and bad-debt risks, and the potential competition from other hospitals in the area choosing to accept assignment. Hospitals choosing not to accept assignment would be those with a relatively small Medicare patient load, or located in an area without other hospitals, or to whom the bad-debt risks appear minimal. A lower rate of assignment is assumed for investor-owned hospitals because they more often tend to locate in areas in which beneficiaries would be able to pay higher out-of-pocket costs. In later years, if the program described for the first years was continued, more hospitals might opt not to accept assignment because the payment incentives would diminish as a share of the prospective rate.

The savings estimate is sensitive to the assignment rate assumption. For example, if assignment is assumed for 75 percent of nonprofit and 50 percent of investor-owned hospitals, as in the AHA's estimate of the proposals's effects, outlays under the proposal would be reduced by about $190 million in fiscal year 1983.[3]

Admissions. The CBO estimate assumes that hospitals would respond to the proposal's implicit incentive to increase admissions. Because payment would be a fixed rate per case, hospitals would have an incentive to increase revenues by increasing the number of Medicare admissions, particularly beneficiaries whose care would cost less than the average. In general, the costs of treating an additional patient would be less than the prospective payment, which would be based on average costs. Furthermore, hospitals might seek patients with less costly diagnoses—possibly patients who would not otherwise have been hospitalized—in order to maximize the number of admissions where there would be a large differential between the reimbursement rate and the cost of treatment.

Although the proposal requires that the Secretary of Health and Human Services limit the growth in Medicare admissions to 2 percent in 1983, this target—which is about 1 percentage point below the increase projected under current policy—is not likely to be met. Experience with utilization review is not encouraging enough to expect that it could completely counterbalance the proposal's powerful incentive for increased admissions. It is particularly doubtful that review performed by the hospital, as specified under the proposal, would be effective enough to meet the 1983 goal, given the hospital's financial interest in having admissions approved. Without utilization review, however, the increase in admissions under the proposal would be even greater.

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[3] American Hospital Association, "American Hospital Association Proposal: Medicare Prospective Fixed Price Payment to Hospitals" (approved by the Executive Committee of the Board of Trustees, American Hospital Association, April 14, 1982).

While the mandate to the Secretary of HHS might ultimately improve the effectiveness of utilization review, achieving the 1983 goal would be very difficult. Many hospitals have experience performing utilization review under the PSRO program, so initially they are likely to be able to demonstrate to the Secretary that they have the capability to perform effective utilization review. If the efforts of these hospitals (and other organizations where the hospital does not conduct review) should fall short of the limit, recognition of the shortfall by HHS would come too late in fiscal year 1983 to make achieving the goal for that year possible.

POTENTIAL EFFECTS OF THE AHA PROPOSAL ON TOTAL HOSPITAL COSTS

A prospective fixed-rate system of hospital payment would offer more incentives for increased efficiency and lower costs than the current system. A prospective system would allow hospitals to keep the difference between the predetermined reimbursement rate and the cost of providing services to the Medicare beneficiary. This is in contrast to proposals that would set a ceiling on growth in a hospital's Medicare costs, which do not encourage hospitals to reduce growth in costs below the ceiling.

Other incentives present in the AHA proposal would limit its cost-reducing effects, however. Pressure to contain costs would be reduced by the opportunities mentioned earlier to shift costs to outpatient services and increase admissions of less costly cases.

Increasing charges to non-Medicare payers would also lessen pressure to reduce costs. While some cost shifting would occur, the proportion of reimbursement reductions shifted to other payers is difficult to predict. Medicare and Medicaid beneficiaries, on average, generate 45 percent of gross hospital revenue in community hospitals, so that, despite the incentive to shift costs, many hospitals with a relatively high proportion of Medicare cases would find it difficult to do so. Moreover, commercial insurers, to whom costs would be shifted, might take actions to make cost-shifting more difficult—for example, by developing preferred provider plans (PPOs), although they could probably not do so very rapidly.

Allowing hospitals to make additional charges to beneficiaries might also reduce the extent of cost containment achieved, despite its potential to increase competition among hospitals. The ability to make charges to patients would reduce the need for hospitals to keep within the prospective payment rate by reducing costs.

Finally, the competitive system provided for in later years under the AHA proposal would be difficult to administer, and some of its specific provisions would limit the likelihood of cost-reducing effects. A hospital's proposed reimbursement rate would have to be considered in terms of the type of services it would provide to Medicare beneficiaries, requiring an assessment of the hospital's case mix. For example, the services purchased from a teaching hospital providing open heart surgery would be different from those purchased from a smaller facility, and the rates would have to differentiate between them. Furthermore, because hospitals that did not submit bids, or whose bids were not approved, would receive the average of accepted bids in the area, there would be no incentive for hospitals to bid low. Limiting beneficiary access to successful bidders, which is not called for in the proposal, might be necessary in order to elicit lower bids from hospitals.

EFFECTS ON BENEFICIARIES

The AHA proposal would probably not have much impact on beneficiaries initially, but they could face higher out-of-pocket costs and reduced access to care in later years. Although the proposal would allow hospitals to bill beneficiaries for the difference, several factors would probably lead most hospitals to accept assignment in the early years of the proposal: potential competition from other hospitals that did not refuse to accept assignment; local political concern; and the favorable reimbursement treatment offered under the proposal.

If the program were continued in later years, hospitals might be less inclined to accept assignment. First, the incentives to do so—adjustments for return-on-equity and capital maintenance—would become smaller relative to the difference between charges and the share of the prospective rate over time. Second, Medicare beneficiaries might increase their supplemental coverage to protect themselves from higher out-of-pocket hospital costs, reducing competitive pressures to avoid such charges. The competitive bidding program outlined for later years would affect the assignment rate, but the effects are difficult to determine because the program is not clearly specified.

While, in theory, beneficiaries could avoid the extra charges by choosing hospitals that accept assignment, in some cases their choice might be determined by where their physician practices or by emergency. Further, hospitals without nearby competitors would be more likely to charge beneficiaries.

Beneficiaries treated in hospitals that did not accept assignment could find their liabilities increased significantly. The $1,000 maximum charge per hospital stay would be burdensome to the average beneficiary. Although some beneficiaries would have supplemental insurance coverage that might pay these extra charges, even they would ultimately pay the charges through higher insurance premiums.

Beneficiary liability would be limited to some degree by the requirement of preserving the Medicare discount. That is, beneficiaries could not be required to pay a differential that would lead to a total payment to the hospital greater than the proportion of charges that would have been paid by Medicare if the current reimbursement system had been paid by Medicare if the current reimbursement system had been maintained. On the other hand, the requirement that the discount be preserved gives hospitals not accepting assignment an incentive to increase charges more rapidly than they otherwise would.

Like other proposals to reduce Medicare payments to hospitals without affecting rates charged to other payers, the AHA proposal might, in the long run, reduce access to hospital services by Medicare beneficiaries. First, some persons would not be able to afford to use hospitals that did not accept Medicare assignment. This is turn could pose problems in beneficiaries' access to physician services, because choice of hospital depends on where physicians have privileges. Second, hospitals with a high proportion of Medicare patients could have financial problems if prospective rates grew more slowly than their costs. If these hospitals were forced to close or reduce their Medicare patient load, access by beneficiaries would be further reduced.

EFFECTS ON OTHER PAYERS

All payers for hospital services stand to benefit from any reductions in costs that occurred in response to prospective reimbursement under Medicare, but commercial insurers could find their competitive position vis-a-vis Blue Cross plans weakened. To the extend that hospitals would pass costs on to other payers, commercial insurers would pay more for hospital care since their plans pay on the basis of hospital charges. Blue Cross plans in many states, in contrast, use a cost-based system similar to that of Medicare. In 1980, the share of charges ultimately reimbursed was 80 percent for Medicare, 86.5 percent for Blue Cross and 92 percent for commercial insurers. Any additional cost shifting would exacerbate this differential.

A prospective system such as the one proposed would lead to less cost shifting than other policies to reduce Medicare costs, however. Because the hospital could keep the difference between the prospective rate and the costs incurred, it would have an incentive to reduce costs rather than shift them. Other methods that would reduce Medicare payments would encourage hospitals to pass costs on.

POSSIBLE VARIATIONS ON THE PROPOSAL

Several changes in specific provisions of the AHA proposal could result in greater savings, or remove some of the proposal's shortcomings. These would: Restructure adjustments to the base; reduce incentives for increased admissions; and make assignment mandatory.

RESTRUCTURE ADJUSTMENTS TO THE BASE

Two changes in calculating the base payment would increase savings and improve incentives for efficiency. First, including savings from Section 223 limits on routine costs in the base would reduce outlays under the proposal by about $300 million in fiscal year 1983. Furthermore, because the limits affect only the most costly hospitals, retaining the penalty in the base price would lessen the tendency of the proposal to reward the highest-cost hospitals the most.

A second adjustment would remove capital costs from the base, which are reimbursed twice under the proposal. Because capital costs are included in the base, the annual inflation adjustment increases reimbursement for them. But the proposal allows an additional passthrough for all capital costs associated with approved projects. Excluding capital costs from the base would avoid this double payment. This would save about $250 million in fiscal year 1983, and $610 million in 1984.

REDUCE INCENTIVES FOR INCREASED ADMISSIONS

Rather than relying solely on utilization review to counter the incentives for increased admissions, the proposal could be revised to include other features to reduce its incentive for increasing admissions and favoring less costly cases. Hospitals could receive reduced payments for admissions beyond a set rate of increase from the previous year's level. For example, admissions beyond 2 percent could be given less weight in determining the hospital's final reimbursement. The reduction could be scaled so that hospitals closer to the predetermined rate would be penalized less than those with very high growth rates.

In addition, the hospital's case mix could be compared to that in its base year, with adjustments made to reflect changes in costliness. Almost all hospitals have diagnostic coding systems that would make use of a simple case mix index feasible at this time. If admissions under both these options were held to their projected increases under current policy, outlays under the proposal would be reduced by $95 million in fiscal year 1983, and by greater amounts in the out-years.

MAKE ASSIGNMENT MANDATORY

Mandatory assignment would prevent the increased beneficiary liability possible under the proposal, and therefore reduce the threat of reduced access to hospital services by Medicare beneficiaries.

In addition, mandatory assignment could increase the cost containment induced by the proposal, as discussed above; and could also increase budget savings in two ways. First, voluntary assignment could direct patients toward more costly hospitals. To the extent that high-cost hospitals chose to accept assignment, patients would be encouraged to use them instead of low-cost hospitals that made extra charges. Second, mandatory assignment could defer some costly provisions designed to make assignment attractive to hospitals, such as capital maintenance allowances.

Chairman JACOBS. Thank you, Doctor.

Mr. Gradison.

Mr. GRADISON. Mr. Chairman, I have no questions, but I do want to thank Mr. Ginsburg for his very valuable testimony.

It certainly sets out the policy issues which face us, and I think can be a useful, valuable touchstone in the decisionmaking process which lies ahead.

Thank you.

Chairman JACOBS. Well, I echo those sentiments.

I think your statement is of substantial value to the committee, and we express our gratitude for your scholarship.

Thank you.

Our next witness is on a panel, Mr. Jack Owen, executive vice president, American Hospital Association; Mr. James L. Moorefield, President, Health Insurance Association of America; and Mr. Burton E. Burton, senior vice president, Aetna Life & Casualty.

I beg your pardon. We have skipped over the General Accounting Office.

They did the same thing to us on the first rule on the floor—false start.

Mr. Ahart.

STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY THOMAS G. DOWDAL, GROUP DIRECTOR

Mr. AHART. I have with me Mr. Tom Dowdal, group director of the Human Resources Division, who will assist me in any questions that we have.

We have a relatively short statement, and I would like to skip parts of it, but I would like to cover it rather thoroughly, with your permission, sir.

Chairman JACOBS. Without objection.

Mr. AHART. This subcommittee and the Congress face very difficult questions in the area of medicare, and basically, where are the reductions going to come from, and, importantly, whether and when they will materialize.

For an entitlement program such as medicare, a budget is essentially an estimate or projection based on a series of assumptions concerning events that will occur in the future.

To a large extent, these events—while perhaps reasonably predictable—are not totally controllable. This is especially true in a program like medicare, where total costs depend to a large extent on the health status of 29 million individual people and the decisions made by hundreds of thousands of health services providers.

Today, we will be discussing (1) some significant cost-saving legislative initiatives related to the 1980 and 1981 budget reconciliation acts which have not been implemented, (2) our views on selected medicare cost savings proposals associated with the 1983 budget, and (3) some opportunities for savings through more effective administration of the program.

UNIMPLEMENTED COST-SAVING AMENDMENTS

The medicare provisions of the Omnibus Reconciliation Act of 1980—Public Law 96-499 approved December 5, 1980—included three relatively large cost-saving provisions. Two of the three have not been implemented. The provision involving the largest savings—over $200 million in both 1982 and 1983—has been implemented. Section 946 of the act provided that medicare's reasonable charges for physicians' services were to be determined based on the reasonable charges in effect on the date the medical service was rendered rather than the date the medicare claim was processed. The amendment was effective July 1, 1981, and implementing regulations were issued in December of that year.

Another significant cost-saving amendment was section 902 of the act which involved savings of about $70 to $80 million a year. This amendment provided that under certain circumstances medicare would pay hospitals on the basis of the State's medicaid skilled nursing home rate for those medicare beneficiaries who no longer require acute hospital services but must remain in the hospital because no skilled nursing bed is available in the community.

The amendment was to become effective on the date on which final implementing regulations are issued, which was to be no later than June 1, 1981. Section 2102 of the Omnibus Budget Reconciliation Act of 1981—Public Law 97-35, approved August 13, 1981—modified this provision with an additional estimated savings in 1982 and 1983 of $60 and $70 million, respectively. The statute provided for an effective date of September 1, 1981. As of May 28, 1982, HHS had not even issued the proposed implementing regulations.

The third significant savings provision in the 1980 Reconciliation Act was section 953, which made medicare the secondary payor in any case where medical care could be paid by any liability insurance policy—including an automobile insurance policy—or under a no-fault insurance plan.

The effective date of this amendment was December 5, 1980, with assumed savings in 1982 of $32 million and in 1983 of $75 million. The proposed regulation to implement the provision was issued on May 17, 1982, and is pending the receipt of public comments and preparation of a final rule.

Although a number of significant cost-saving amendments in the 1981 budget reconciliation act related to increased beneficiary deductibles have been implemented, two significant cost-saving amendments pertaining to the end-stage renal disease program have not been.

Section 2145 of the act provided for the development of cost-based incentive reimbursement rates for in-facility and home kidney dialysis services. The effective date of this amendment was October 1, 1981, and implementing regulations were required no later than that date. The estimated savings were $105 million for 1982 and $130 million for 1983.

Proposed regulations were published on February 12, 1982, and comments are being analyzed. The final regulations are expected to be sent to the Office of the Secretary in August 1982. That will be about a 1-year delay.

Section 2146 of the 1981 act provided for medicare to become the secondary payor for the first 12 months after an individual had been determined to be eligible for end-stage renal payments if the beneficiary has private insurance coverage through an employer group health plan. The effective date of this amendment was October 1, 1981, and the estimated savings were about $95 million for 1982 and $165 million for 1983. Proposed regulations were issued on May 17, 1982, and are now pending the receipt and analysis of public comments and preparation of a final rule.

In summary, the 1980 and 1981 reconciliation acts included five major cost-saving amendments representing estimated 1982 medicare savings of about $370 million, which will not materialize because the amendments have not been implemented.

COMPLEXITY OF CURRENT PROPOSALS

We believe, as many others do, as was witnessed here this morning, that it is essential to reform medicare reimbursement methods, especially those for hospitals, to provide them with incentives to hold down their cost increases. This is especially true for hospital ancillary services, which represent a major and growing portion of total hospital costs, and where, in the main, medicare has very few operating mechanisms for holding down costs.

However, we do not believe any of the proposals to control hospital costs that we are aware of would result in short term savings because of the complexity of implementing them. Nor do we have any proposals to offer for major short-term savings in hospital reimbursements. Nevertheless, this should not dissuade the Congress from seeking longer term solutions.

If substantial sums are to be saved from the medicare program, for example, the $4.1 billion reduction included in the Senate-passed version of the first concurrent budget resolution, such savings must be realized primarily from one or a combination of three sources—(1) payments to hospitals which represent about 75 percent of medicare payments, (2) increased beneficiary cost sharing, and (3) transfer of costs to other insurers. The options for medicare savings being discussed include all three sources. For example,

The proposal to establish reimbursement limits on the maximum amount payable for hospital ancillary services according to one estimate would lower payments to hospitals by $660 million in fiscal year 1983.

The proposal to reduce from 100 percent to 80 percent medicare's portion of allowable inpatient hospital radiologist/pathologist charges is estimated to save medicare $145 million. Most of the medicare savings would be borne by the beneficiaries through out-of-pocket payments for these services and increased medigap insurance policy premiums.

The proposal to make medicare secondary to other insurance for the working aged is estimated to save $610 million and would result in increased costs to private insurers and presumably increased premiums for private insurance.

As discussed previously, the track record has not been good for implementing the medicare cost-savings provisions of the 1980 and 1981 reconciliation acts when the source of the savings was decreased payments to providers or transferring costs to other insurers.

On the other hand, provisions resulting in increased beneficiary cost sharing have been implemented rather expeditiously. We suspect that this pattern will continue with any cost-savings proposals legislated this year.

We believe that the primary reasons for the difference in the time taken to implement legislative changes is the complexity of the subject matter and the degree of administrative discretion permitted in implementation. Normally, changes affecting beneficiary cost-sharing increases have been relatively simple while those affecting providers and other insurers have been much more complex and give the administrative agency wider latitude in implementation.

For example, when the Congress increased the part B deductible from $60 to $75 effective January 1, 1982, essentially all that HHS had to do to implement the change was to change $60 to $75 wherever it appeared in medicare regulations and manuals and tell the computers not to pay anything until a beneficiary had incurred $75 in covered expenses in a year rather than the previous $60. HHS did not really have to be concerned with comments from the public on proposed regulations because it was doing precisely what the law called for. Implementation of this provision was estimated to save $120 million in fiscal year 1982.

On the other hand, when the Congress directed HHS in 1981 to revise the reimbursement system for the end stage renal disease program, implementation required HHS to make numerous decisions and judgments. We understand that, before the provision was enacted, HHS had in mind a methodology to implement it. In spite of this, HHS had to gather additional data on renal dialysis costs, fully develop a complex methodology for establishing payment rates, develop the regulations necessary for implementation, and publish the proposed regulations and methodology for public comment.

The law was approved on August 13, 1981, and the provision had an effective date of October 1, 1981, but proposed regulations were not published for comment until February 12, 1982, and the final regulations are not expected to go to the Office of the Secretary until August 1982.

Thus, the implementation of the renal disease amendment will probably not occur until a year after its effective date. The estimated savings for fiscal year 1982 at the time of enactment were about $100 million.

I would like to point out that we would support a number of the proposals that have been raised to control medicare costs. For example, the proposal to control payments for hospital ancillary services and the proposal to limit the use of percentage contracts by providers which we recommended in 1978. Our concern is not so much with the concept of many of the proposals but rather, because of the complexity of implementing the proposals, whether savings will materialize in the short term.

PROGRAM ADMINISTRATION

I would like to turn now to an area where we believe some short-term savings could be realized. It seems to us to be much easier to achieve short-term savings by thoroughly enforcing current program requirements than by trying to implement complex new requirements.

In this connection, we note that over the last several years the administrative budget for medicare has remained relatively static. The administration's budget for fiscal year 1983 proposed to maintain medicare's administrative budget at its current level. Considering inflation, the administrative budget in real dollars has obviously decreased since 1980. We question the wisdom of attempting to limit administrative costs at the same time that numerous legislative requirements are supposed to be implemented.

We note that Congress attempted to include in the continuing resolution for fiscal year 1982 more funds than requested by the administration for the carriers and intermediaries which control medicare payments.

Also, in May 1981, testimony before a Senate committee, we questioned the wisdom of large proposed reductions—67 percent less—in the amount allocated to intermediaries to audit provider cost reports. We did not see how reducing a cost effective administrative function which was producing $7 in savings for every $1 spent would result in net savings to medicare.

Although audit funds were not cut as drastically as originally contemplated, they were cut significantly. We believe an increase in provider audits would result in short-term savings, assuming the intermediaries can hire experienced auditors.

The administration's 1983 budget includes a reduction of $330 million for a cost-saving regulatory initiative aimed at giving the medicare contractors greater responsibility for identifying overutilization of services. However, there is no increase for 1983 in the contractors' 1982 funding level—$704 million—to implement this utilization review initiative.

Although we do not know the basis for the $330 million estimate, our ongoing review at nine medicare carriers shows that automated prepayment utilization review of medicare claims for physician services has been quite cost effective in identifying, and preventing payment for, medically unnecessary services.

Overall, the carriers we visited had experienced a cost-benefit ratio of over $7 saved for each dollar spent in the prepayment utilization review activity. However, the range of carrier performance in terms of the cost-benefit ratios, the amount of denials based on workloads, and the number and type of automated edits used by the carriers varied widely. This suggests to us that expanding this activity at those carriers with comparatively poor performance indicators and minimal utilization review effort should result in significant additional savings.

Ironically, as part of implementing the 1982 budget restraints, HCFA reduced the funding for this cost-effective activity by 50 percent.

That concludes my statement. We will be happy to answer any questions you may have.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

SUMMARY

GAO believes the basic questions about Medicare savings facing the Subcommittee and the Congress are—where are the savings going to come from and whether and when they will materialize?

The Department of Health and Human Services has not been very successful in implementing the Medicare cost-savings provisions included in the 1980 and 1981 reconciliations acts, particularly provisions which would decrease payments to providers or transfer costs to other insurers. Five major provisions have not been implemented and, therefore, estimated savings of about $370 million for 1982 did not materialize.

GAO believes that the primary reasons for the difference in the time taken to implement legislative changes is the complexity of the subject matter and the degree of administrative discretion permitted in implementation. Normally, changes affecting beneficiary cost-sharing increases have been relatively simple and have been implemented, while those affecting providers and other insurers have been more complex, have given the administrative agency wider latitude in implementation, and have not been implemented. GAO suspects that this pattern will continue with any cost-savings proposals enacted this year.

GAO believes there are some opportunities to reduce Medicare costs by increasing administrative budgets for cost-effective functions, such as audits of provider cost reports and prepayment utilization review.

STATEMENT

Mr. Chairman and members of the Subcommittee, we are pleased to be here today to discuss some of the implications of the 1983 Budget Proposals relating to the Medicare Program. Medicare which became effective for persons aged 65 and over on July 1, 1966, is a nationwide health insurance program for 26 million aged and 3 million disabled persons. The eligibility requirements and benefit structure are essentially uniform throughout the country.

In recent years, the cost of Medicare in terms of outlays has increased by between about 16 and 20 percent annually since 1976. The Administration's 1983 Budget, assuming no changes in law or regulations, is more or less consistent with this historical trend. That is, the actual 1981 outlays were about $42.5 billion and the estimated 1982 outlays are about $49.9 billion—an increase of 17 percent. The 1983 estimate, assuming no program changes, is $57.9 billion or an increase from 1982 of about 16 percent. The Administration's 1983 budget, however, includes a number of regulatory and proposed legislative cost-saving initiatives estimated to total about $2.5 billion, which would bring the 1983 proposed outlays down to $55.4 billion or an 11-percent increase over 1982.

The Senate's 1983 Budget Resolution calls for Medicare reductions of $4.1 billion which equates to an increase in outlays from 1982 to 1983 of about 8 percent. The proposal adopted by the House, as we understand it, calls for reductions of about $3.2 billion or an increase of about 9 percent.

We believe that the basic questions facing the Subcommittee and the Congress are—where are these reductions going to come from and whether and when they will materialize? For an entitlement program such as Medicare, a budget is essentially an estimate or projection based on a series of assumptions concerning events that will occur in the future. To a large extent, these events—while perhaps reasonably predictable—are not totally controllable. This is especially true in a program like Medicare, where total costs depend to a large extent on the health status of 29 million individual people and the decisions made by hundreds of thousands of health services providers.

Today we will be discussing (1) some significant cost saving legislative initiatives related to the 1980 and 1981 budget reconciliation acts which have not been implemented, (2) our views on selected Medicare cost savings proposals associated with the 1983 budget, and (3) some opportunities for savings through more effective administration of the program.

UNIMPLEMENTED COST-SAVING AMENDMENTS

The Medicare provisions of the Omnibus Reconciliation Act of 1980 (Public Law 96–499 approved December 5, 1980) include three relatively large cost-saving provisions.[1] Two of the three have not been implemented. The provision involving the largest savings—over $200 million in both 1982 and 1983—has been implemented. Section 946 of the Act provided that Medicare's reasonable charges for physicians' services were to be determine based on the reasonable charges in effect on the date the medical service was rendered rather than the date the Medicare claim was processed. The amendment was effective July 1, 1981, and implementing regulations were issued in December of that year.

Another significant cost-saving amendment was section 902 of the Act which involved savings of about $70 to $80 million a year. This amendment provided that under certain circumstances Medicare would pay hospitals on the basis of the State's Medicaid skilled nursing home rate for those Medicare beneficiaries who no longer require acute hospital services but must remain in the hospital because no skilled nursing bed is available in the community. The amendment was to become effective on the date on which final implementing regulations are issued, which was to be no later than June 1, 1981. Section 2102 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–25, approved August 13, 1981) modified this provision with an additional estimated savings of 1982 and 1983 of $60 and $70 million, respectively. The statute provided for an effective date of September 1, 1981. As of May 28, 1982, HHS had not even issued the proposed implementing regulations.

The third significant savings provision in the 1980 Reconciliation Act was section 953 which made Medicare the secondary payor in any case where medical care could be paid by any liability insurance policy (including an automobile insurance policy) or under a no-fault insurance plan. The effective date of this amendment was December 5, 1980, with assumed savings in 1982 of $32 million and in 1983 of $75 million. The proposed regulation to implement the provision was issued on May 17, 1982, and is pending the receipt of public comments and preparation of a final rule.

Although a number of significant cost-saving amendments in the 1981 budget reconciliation act related to increased beneficiary deductibles have been implemented, two significant cost-saving amendments pertaining to the end-stage renal disease program have not been. Section 2145 of the Act provided for the development of cost-based incentive reimbursement rates for in-facility and home kidney dialysis services. The effective date of this amendment was October 1, 1981, and implementing regulations were required no later than that date. The estimated savings were $105 million for 1982 and $130 million for 1983. Proposed regulations were published on February 12, 1982, and comments are being analyzed. The final regulations are expected to be sent to the Office of the Secretary in August 1982.

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[1] This refers to amendments where the estimated savings for 1982 and/or 1983 exceeded $50 million a year.

Section 2146 of the 1981 Act provided for Medicare to become the secondary payor for the first 12 months after an individual had been determined to be eligible for end-stage renal payments if the beneficiary has private insurance coverage through an employer group health plan. The effective date of this amendment was October 1, 1981, and the estimated savings were about $95 million for 1982 and $165 million for 1983. Proposed regulations were issued on May 17, 1982, and are now pending the receipt and analysis of public comments and preparation of a final rule.

In summary, the 1980 and 1981 reconciliation acts included five major cost-saving amendments representing estimated 1982 Medicare savings of about $370 million which will not materialize because the amendments have not been implemented.

COMPLEXITY OF CURRENT PROPOSALS

We believe, as many others do, that it is essential to reform Medicare reimbursement methods, especially those for hospitals, to provide them with incentives to hold down their cost increases. This is especially true for hospital ancilliary services, which represent a major and growing portion of total hospital costs, and where, in the main, Medicare has very few operating mechanisms for holding down costs. However, we do not believe any of the proposals to control hospital costs that we are aware of would result in short-term savings because of the complexity of implementing them. Nor do we have any proposals to offer for major short-term savings in hospital reimbursements. Nevertheless, this should not dissuade the Congress from seeking longer term solutions.

If substantial sums are to be saved from the Medicare program, for example, the $4.1 billion reduction included in the Senate passed version of the first concurrent budget resolution, such savings must be realized primarily from one or a combination of three sources—(1) payments to hospitals which represent about 75 percent of Medicare payments, (2) increased beneficiary cost sharing, and (3) transfer of costs to other insurers. The options for Medicare savings being discussed include all three sources. For example:

The proposal to establish reimbursement limits on the maximum amount payable for hospital ancilliary services according to one estimate would lower payments to hospitals by $660 million in fiscal year 1983.

The proposal to reduce from 100 percent to 80 percent Medicare's portion of allowable inpatient hospital Radiologist/Pathologist charges is estimated to save Medicare $145 million. Most of the Medicare savings would be borne by the beneficiaries through out-of-pocket payments for these services and increased Medi-gap insurance policy premiums.

The proposal to make Medicare secondary to other insurance for the working aged is estimated to save $610 million and would result in increased costs to private insurers and presumably increased premiums for private insurance.

As discussed previously, the track record has not been good for implementing the Medicare cost savings provisions of the 1980 and 1981 reconciliation acts when the source of the savings was decreased payments to providers or transferring costs to other insurers. On the other hand, provisions resulting in increased beneficiary cost sharing have been implemented rather expeditiously. We suspect that this pattern will continue with any cost-savings proposals legislated this year.

We believe that the primary reasons for the difference in the time taken to implement legislative changes is the complexity of the subject matter and the degree of administrative discretion permitted in implementation. Normally, changes affecting beneficiary cost sharing increases have been relatively simple while those affecting providers and other insurers have been much more complex and gave the administrative agency wider latitude in implementation. For example, when the Congress increased the part B deductible from $60 to $75 effective January 1, 1982, essentially all that HHS had to do to implement the change was to change $60 to $75 wherever it appeared in Medicare regulations and manuals and tell the computers not to pay anything until a beneficiary had incurred $75 in covered expenses in a year rather than the previous $60. HHS did not really have to be concerned with comments from the public on proposed regulations because it was doing precisely what the law called for. Implementation of this provision was estimated to save $120 million in fiscal year 1982.

On the other hand, when the Congress directed HHS in 1981 to revise the reimbursement system for the end stage renal disease program, implementation required HHS to make numerous decisions and judgments. We understand that, before the provision was enacted, HHS had in mind a methodology to implement it. In spite of this, HHS had to gather additional data on renal dialysis costs, fully develop a complex methodology for establishing payment rates, develop the regulations necessary for implementation, and publish the proposed regulations and methodology for public comment.

The law was approved on August 13, 1981, and the provision had an effective date of October 1, 1981, but proposed regulations were not published for comment until February 12, 1982. We understand that voluminous comments were received raising questions about the decisions and judgments HHS made in preparing the proposal. Also, several hearings have been held related to the proposal at which numerous issues arose. We understand that the comments are currently being analyzed and that the regulations, with any revisions deemed necessary, and an analysis of the comments is planned to be submitted to the Office of the Secretary of HHS in August 1982. Thus, the implementation of the renal disease amendment will probably not occur until a year after its effective date. The estimated savings for fiscal year 1982 at the time of enactment were about $100 million.

I would like to point out that we would support a number of the proposals that have been raised to control medicare costs. For example, the proposal to control payments for hospital ancillary services and the proposal to limit the use of percentage contracts by providers which we recommended in 1978. Our concern is not so much with the concept of many of the proposals but rather, because of the complexity of implementing the proposals, whether savings will materialize in the short term.

PROGRAM ADMINISTRATION

I would like to turn now to an area where we believe some short-term savings could be realized. It seems to us to be much easier to achieve short-term savings by thoroughly enforcing current program requirements than by trying to implement complex new requirements. In this connection, we note that over the last several years the administrative budget for Medicare has remained relatively static. The Administration's budget for fiscal year 1983 proposed to maintain Medicare's administrative budget at its current level. Considering inflation, the administrative budget in real dollars has probably decreased since 1980. We question the wisdom of attempting to limit administrative costs at the same time that numerous legislative requirements are supposed to be implemented. We note that the Congress attempted to include in the continuing resolution for fiscal year 1982 more funds than requested by the Administration for the carriers and intermediaries which control Medicare payments. Also, in May 1981 testimony before a Senate Committee, we questioned the wisdom of large proposed reductions (67 percent less) in the amount allocated to intermediaries to audit provider cost reports. We did not see how reducing a cost-effective administrative function which was producing $7 in savings for every $1 spent would result in net savings to Medicare. Although audit funds were not cut as drastically as originally contemplated, they were cut significantly. We believe an increase in provider audits would result in short-term savings, assuming the intermediaries can hire experienced auditors.

The Administration's 1983 Budget includes a reduction of $330 million for a cost-saving regulatory initiative aimed at giving the Medicare contractors greater responsibility for identifying overutilization of services. However, there is no increase for 1983 in the contractors' 1982 funding level ($704 million) to implement this utilization review initiative. Although we do not know the basis for the $330 million estimate, our ongoing review at nine Medicare carriers shows that automated prepayment utilization review of Medicare claims for physician services has been quite cost effective in identifying, and preventing payment for, medically unnecessary services.

Overall, the carriers we visited had experienced a cost benefit ratio of over $7 saved for each dollar spent in the prepayment utilization review activity. However, the range of carrier of performance in terms of the cost benefit ratios, the amount of denials based on workloads, and the number and type of automated edits used by the carriers varied widely. This suggests to us that expanding this activity at those carriers with comparatively poor performance indicators and minimal utilization review effort should result in a significant additional savings.

Ironically, as part of implementing the 1982 budget restraints, HCFA reduced the funding for this cost effective activity by 50 percent.

That concludes my statement. We will be happy to answer any questions you may have.

Chairman JACOBS. Thank you.

Mr. Gradison.

Mr. GRADISON. Thank you for your excellent testimony.

I have one specific question that has been concerning me for some time.

Medicare policy toward reimbursement of hospital capital expenses along with recent changes in the tax law concerning accelerated cost recovery are being criticized by some observers as significantly contributing to inflation and health care costs. Special concern is the effect of mergers and acquisitions on hospital per diem costs. We have seen a fair number of situations now in which the sale of a hospital results in increasing the base, which is the method used in calculating the per diem return on capital.

It is argued that since medicare reimburses for interest expense, depreciation and return on net equity, and, in addition, since accelerated cost recovery is allowed under the recently enacted tax legislation, Federal medicare and tax policies are the driving force behind these mergers and acquisitions.

Many of these transactions are being criticized as merely adding new costs, but no new capacity to the care system.

Would you care to comment on what you may be doing or contemplating doing to look into this?

Mr. AHART. We are aware of the problem, and the situation. If you look at the medicare program, itself, it tends to be somewhat neutral on this particular issue, because the medicare program allows basically straight-line depreciation, with some exceptions.

Medicare pays cost reimbursement, based on that straight-line depreciation, and limits the depreciable base to the reproduction costs, less prior depreciation; so medicare has some limits on depreciation to avoid possible abuse.

When you couple, however, medicare's depreciation payments with the tax side of the equation, where people can gain through the accelerated depreciation technique from a tax standpoint, obviously it can provide an incentive to buy and sell hospitals. You can increase your cashflow considerably, and your real profit considerably, by a sale and purchase perhaps with inflated prices, which can result in additional charges and an additional depreciation base to write off an investment for tax purposes.

I don't know if we have much to comment by way of a solution on that.

It is a potential problem and we will give consideration to it, but we have no clear answers on it at this time.

Mr. Dowdal might have something to add to that.

Mr. DOWDAL. I would say about the same thing. We are currently performing some work in this area, trying to determine what one particular major acquisition of a hospital chain has had on medicare payments to those hospitals involved.

Mr. GRADISON. Well, I certainly look forward to the results of your study. Thank you very much for your testimony.

Chairman JACOBS. Mr. Rangel.

Mr. RANGEL. No questions.

Chairman JACOBS. Mr. Holland.

Mr. HOLLAND. No questions.

Chairman JACOBS. Mr. Ahart, if Congress expanded section 223 limits, as indicated by the budget, do either of you gentlemen suppose that the administration can implement those expansions by the first day of October 1982?

Mr. AHART. I guess we would have to say no, an emphatic no, based on the history of it.

As I pointed out in my testimony, there are provisions which are fairly easy to implement, and that is basically where there is not much discretion left to the administrative agency; that is, where you pass a provision which tends to be self-executing, the implementation of it tends to be somewhat ministerial, and that is easy to do.

If you get involved in situations such as section 223 limits, you are establishing an objective and leaving to the department the very difficult task of balancing the interests that are involved and would be affected in meeting that objective.

That is a very difficult task, one which can't be done in a month, 2 months.

As pointed out in my testimony, in some of the provisions in the 1980 act have still not been made effective, and it is for this reason that the Department has taken so long—perhaps they have taken too long, I don't know, but they have had the task that they are charged with of balancing the varied interests, and that is a time-consuming process.

Chairman JACOBS. Do you think it is inherently or politically necessary to make such law more obscure as it applies to providers, as distinguished from its application to beneficiaries?

Mr. AHART. To some degree, Mr. Chairman. It would be very difficult to avoid a charge of being arbitrary, and still have a law which affects providers with the great complexities that there are, without leaving a lot of discretion to the people that have to administer it and work those things out.

It is very difficult in the legislative process to deal with an awful lot of the complexities. I don't think the committees have that much time, and I don't think that the legislative process would tolerate the kind of time that would be involved to work out all of the minor problems and the minor interests that are involved in implementing one of these things.

So I think it is a practical necessity, when you get involved in these complex areas, to have some leadtime built into the law so it can be done thoughtfully and consider the inputs of a lot of people in working out the fine points of those kinds of regulations.

Chairman JACOBS. On a scale from 1 to 10, how would you rate most of the legislation in the past few years in terms of efficiency, given those contingencies you just mentioned. Can we improve it?

Mr. AHART. I don't know if I could rate it on a scale.

Chairman JACOBS. Is there substantial improvement that can be brought about in terms of specificity in the statute?

Mr. AHART. The subject matter that you deal with almost dictates the degree to which you can be specific in the statute.

If you are dealing with a change in the level of a deductible, that is very easy to do in a statute.

Chairman JACOBS. I got that testimony.

Pick one out, for example, that applies to the providers. Can you pick out any provision of the statute, in the last 5 or 6 years, that you think substantially could be simplified?

Mr. **Ahart**. Let me turn to Mr. Dowdal for some help on this one.

Mr. **Dowdal**. It would be very difficult for me to give, off the top of my head, a particular provision that could have been made more specific and easier to implement.

There are in almost any provision you look at, there are certain ways that it could have been changed, where it would have made it a little easier to implement, but——

Chairman **Jacobs**. You don't see any glaring example in your mind right at the moment?

Mr. **Dowdal**. I can't think of one right off the top of my head.

Chairman **Jacobs**. Thank you both for your help.

Now, Mr. Jack Owen, executive vice president of the American Hospital Association; James Moorefield, president, HIAA; and Burton E. Burton, senior vice president, Aetna Life & Casualty.

You may proceed as you wish.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. **Owen**. Mr. Chairman, I am Jack Owen, executive vice president of the American Hospital Association and director of its Washington office. AHA is the principal national organization of hospitals, representing some 6,300 member institutions and more than 35,000 personal members.

I am pleased to have this opportunity to discuss our proposal for prospective payment of hospitals under medicare, which AHA has developed as its contribution to the congressional debate over how to restrain the growth in medicare spending.

I would like to summarize my statement, if I may.

We believe that our perspective of payment system would be better for Government, for the beneficiaries, and for the hospitals, and that, of course, is why we are advocating it.

Let me just start off by saying that we have sent a proposal to each member of this subcommittee, and you should have copies of that.

We have begun drafting legislation which would put this proposal into effect, and the Congressional Budget Office has been asked to analyze our proposal, and many of you have seen the basis of their May 28 drafting analysis in which several areas CBO believed it would increase the medicare fiscal 1983 outlays, which was contrary to our goal, and we have written to Chairman Rostenkowski that although we disagreed with several of the CBO assumptions, we would make the technical refinements to meet the CBO benchmarks.

We have done that, and we have a report from CBO indicating that there were savings.

Mr. Ginsburg commented earlier on that.

Our willingness, gentlemen, is to work right now on a constructive change in the medicare program.

We think in overview that such a program must be relatively easy to understand, easy to implement and easy to administer.

Second, it should provide a reasonable degree of financial predictability for the Government, for the beneficiaries, and for the hospitals.

It should permit management flexibility, and reward cost-effective performance.

Lastly, it should protect against arbitrary shortfall payments.

Our proposal would apply to all hospitals located in the standard metropolitan statistical areas with 100 or more beds. This would cover 92 percent of all medicare hospital payments.

Prospective payment would initially apply only to medicare part A services, which would be for the first 2 years and allow more waivers for innovative payment systems now in progress in a couple of States and could be innovatively, started in other States.

We also believe that the HHS could add some additional services to the inpatient portion, such as emergency medical services and a few other things, as we go along.

The entire system that we are recommending would sunset in 4 years and at that time we could examine the system and make changes, if necessary.

That is one of the problems we have got with today's medicare legislation.

The heart of the system is a prospectively determined average price for each beneficiary discharge. If the actual cost of that discharge is more, then the hospital gets no pay.

If it is less, the hospital keeps the money. It provides a powerful incentive to keep costs at the prices fixed, and the more efficient, the more a hospital is rewarded.

We think a preliminary base could be derived from the hospital's most recently filed medicare cost report and update it through fiscal 1982 with a final costs through submission of a special medicare cost report.

We have done this in recognition of CBO analysis which our original proposal let the hospital take the higher of either the preliminary or the final cost.

Now, we have said that we would bring this to the lower figure.

The price adjustment index fixed at 8 percent produces a portion of the savings we were talking about. Future index would be established by an independent panel of economists, neither with HHS nor with the hospitals, but independent, so that we would all agree on it.

Our hospitals in our proposal would have an option of accepting a price in full or billing the beneficiary for those who did not want to participate, but there would be a limit of not more than $1,000 being paid by any beneficiary.

We think the proposal has enough strong incentives that most hospitals will accept an assignment.

The assignment will give them a return on equity for a capital maintenance allowance, and we believe that this would be enough to convince most hospitals to take an assignment.

Community attitudes toward acceptance is out there, and most hospitals boards and trustees are concerned about the aged and want to be sure they are taken care of.

In a telephone survey, we think that 75 percent of the hospitals would participate.

CBO thinks 90 percent would participate.

We think it is important that the option be in there, however, because, as medicare prices are squeezed down, there comes a time when a hospital must either contract or not contract, and by having the option, it gives flexibility.

We have dropped our 5-day cycle of payments which increases the amount of money in this fiscal year, but would postpone it to the next fiscal year, and the only thing I have to say on that, there is a problem of rate lag, and we are now running several weeks behind in payments.

When our hospitals are being paid so closely to their costs, we cannot afford much rate lag.

We think it is most important that utilization be controlled. We think this is a job of HHS or the intermediaries, and we believe that we can limit the admissions to a 2-percent increase versus a 3.5 percent, which CBO predicts.

If we are correct, this would create another savings of some $430 million.

I would caution you, though, that savings, any savings, can reach a point where it may adversely affect the access or the quality of care.

Certainly the May 30 New York Times report on what is happening in New York City to the medicaid program is worthy of note.

We strongly oppose continuation of 223 as a payment limit. It groups hospitals; it is unfair, and actions that are limited by other institutions tend to regulate the actual operation of the hospital and not the hospital's operation itself.

We urge this subcommittee to reject proposals to expand section 223 and focus on a prospective rate approach, which holds out the promise of some lasting change in hospital cost performance in medicare costs growth.

We are ready to work with you and help make these changes in the right direction.

[The prepared statement follows:]

Statement of the American Hospital Association

Mr. Chairman, I am Jack Owen, Executive Vice President of the American Hospital Association and Director of its Washington office. AHA is the principal national organization of hospitals, representing some 6,300 member institutions and more than 35,000 personal members. I am pleased to have this opportunity to discuss our proposal for prospective payment of hospitals under Medicare, which AHA has developed as its contribution to the Congressional debate over how to restrain the growth in Medicare spending.

In the brief time available this morning, let me review the progress we have made on our proposal over the past several months, provide an overview of the proposal as it is currently stands, and summarize why we believe our prospective payment system would be better—for government, beneficiaries, and hospitals—than other alternatives which currently are being considered in Congress for Fiscal Year 1983.

PROGRESS THUS FAR

In our testimony before this Subcommittee on March 2, we said that hospitals share Congress' and the Administration's concern over the continued rapid increase in the cost of providing hospital services, and the resultant pressure on the federal Budget. We pointed out that hospitals continue to find themselves caught in the entangling web of conflicting pressures and expectations, which stimulate demand for, and provision of, health care services while payments to hospitals are being restricted from virtually all sources, jeopardizing some institutions' viability.

In that testimony, we called for an end to short-range, narrowly-focused tinkering with Medicare reimbursement and committed AHA to working with Congress on fundamental change. Since March, we have acted on this commitment, drawing together some of the most respected, creative leaders in the hospital field to develop a detailed proposal for paying hospitals for Medicare services on a prospectively determined basis. Our goal was to devise a workable system which would stimulate hospital efficiency, provide hospitals with management flexibility to adapt the system to local contingencies, restrain the growth in Medicare outlays by $1 billion in fiscal year 1983, and change the direction of Medicare reimbursement policy toward positive incentives and away from counterproductive penalties.

In April, we sent a description of our proposal to each member of this Subcommittee, as well as to members of the Senate Finance Committee. During the following weeks, we held a series of briefings for interested Members of Congress and staff, as well as representatives of other elements of the health care field.

We also began drafting legislation to implement our proposal. The drafting of a bill, as expected, brought to light myriad technical questions which had to be decided one way or another in making precise changes in the Medicare statute. As we delved more deeply into these technical issues, we refined our bill through successive drafts. That process continues.

The Congressional Budget Office was asked by several congressional committees to analyze our proposal. To assist CBO, we provided its staff with an early version of our draft legislation, which became the basis for CBO's May 28 draft analysis. That analysis, which was provided informally to the committees' staffs, identified several elements of the bill which, in CBO's view, would increase Medicare fiscal year 1983 outlays contrary to a basic goal of our proposal.

After reviewing CBO's draft analysis, we wrote to Chairman Rostenkowski and to Senate Finance Committee Chairman Dole on June 3, saying that while we disagree with several of the assumptions used in assessing our bill, we would make several technical refinements, using CBO's analysis as a benchmark. We reiterated our goal of designing a prospective payment system which would reduce Medicare growth in fiscal year 1983. We renewed our commitment to working with the House Ways and Means and Senate Finance Committees to make fundamental reforms.

I do not know how to communicate more clearly to Congress our willingness to work—right now—on constructive change in the Medicare program. We commend this Subcommittee for holding this hearing and trust that it will result in the next step forward: taking our proposal and including it in the budget package which you draft later this summer.

Your interest in constructive change contrasts with that among some members of the Senate Finance Committee, who, despite their professed intention to make basic, positive changes, have not responded to our proposal and seem bent on repeating the past mistake of making short-term changes which will merely perpetuate Medicare payment shortfalls, counterproductive incentives, and cost-shifting. We simply do not accept the offered excuse that time has not been available to consider workable proposals that would establish incentives for restraint. Medicare spending constitutes about 5 percent of the fiscal year 1983 federal budget, and the program's 29 million beneficiaries and thousands of providers deserve more serious consideration of its future than some in Congress seem willing to give it.

THE PROSPECTIVE PAYMENT PROPOSAL

Let me now provide an overview of our proposal, and our reaction to CBO's May 28 analysis. We have provided copies of our draft bill to the majority and minority staffs of the Subcommittee. The objective of our proposal is a prospectively determined fixed price payment system which: is relatively easy to understand, implement, and administer; provides a reasonable degree of financial predictability for the government, beneficiaries, and hospitals; permits management flexibility and rewards cost-effective performance; and protects against arbitrary payment shortfalls.

This system would be applied to all hospitals located in Standard Metropolitan Statistical Areas (SMSAs) and to hospitals with 100 or more beds which are located outside SMSAs. It would cover 92 percent of all Medicare hospital payments. In addition, small rural hospitals could choose to be covered by the system; otherwise they would remain on the current retrospective reimbursement system.

Prospective payment initially would apply only to Medicare Part A services, i.e., acute inpatient hospital services, for the first two years. As experience is gained, HHS would propose to Congress complementary payment systems for other hospital services, for example, outpatient and emergency services.

Our proposal would encourage innovation in payment systems by requiring HHS to grant waivers to hospitals and states for systems offering payment predictability and comparable Medicare savings. Moreover, after two years, hospitals would elect to enter into price negotiation with HHS for Medicare services. The entire system would have a four-year sunset, and statutorily would establish a scheduled review by Congress, HHS, hospitals, and beneficiaries to examine the system and consider modifications or replacement. We believe that had such reviews been a feature of Medicare in the past, today's problems could have been corrected more easily.

Each hospital covered by the system would be paid a prospectively determined average price for each beneficiary discharge. If, for a given discharge, the hospital's actual cost was more than the fixed price, Medicare would not pay the difference. If the actual cost was below the fixed price, the hospital would receive the pre-established amount. This is the heart of the system: a hospital would have a powerful incentive to keep its costs at the fixed price, or below it. The more cost-efficient the hospital, the greater would be its reward.

For each covered hospital, the fixed price would be established annually by updating a base-year price with a price adjustment index reflecting increases in hospital input prices (goods and services used in operation). The base year would be the hospital's actual average reimbursable cost per discharge from July 1, 1981 through June 30, 1982, without Section 223 (of Public Law 92-603) penalties or adjustments for a return on equity, and updated through September 30, 1982.

For the initial program year, beginning October 1, 1982, the fixed price would be established in two steps to permit the program to get underway quickly while allowing a subsequent adjustment as final performance data are acquired. A preliminary base would be derived from the hospital's most recently filed Medicare cost report, updated through the end of fiscal year 1982 by a monthly factor reflecting current national hospital cost growth. This initial base would be used for calculating the fiscal year 1983 fixed price until final base could be established, through submission of a special Medicare cost report showing each hospital's actual cost performance up to June 30, 1982 and updated to October 1. The hospital's fixed price would then be adjusted to reflect the final base.

This feature is a recognition of CBO's analysis, which pointed out that our earlier version permitted a hospital to take advantage of the higher of the initial or final base, and that the monthly adjustment factor should be somewhat lower now than AHA had estimated earlier in the spring.

The price adjustment index would reflect the annual measurement of hospitals' input prices. For fiscal year 1983, the index would be fixed at 8 percent, to produce a portion of the savings. In subsequent years, the index would be computed by a panel of economists independent of HHS and hospitals. We believe this independence is essential to preclude manipulation and distortion of the system, and to establish the principle that hospitals should not be penalized for the price inflation induced by other segments of the health care economy.

An individual hospital's price would be adjusted to reflect incremental increased in depreciation, interest, and related financing costs resulting from either state government-approved capital expenditures or capital projects needed to meet facility codes and standards. Beginning in fiscal year 1984, one percentage point would be added to the index to account for the cost of new technology.

The price adjustment feature has been refined to accommodate CBO's finding that some of the fiscal year 1983 Medicare savings could be realized only if the index were limited to 8 percent and the technology factor were not added.

Covered hospitals would have an annual option of either accepting the Medicare price payment in full for all beneficiary discharges that year ("accept assignment") or reserve the option to bill beneficiaries for the difference between Medicare rates and the hospital's charges, but no more than $1,000 per discharge. Current beneficiary copayments and deductibles would remain in effect.

The system would provide strong incentives to hospitals for accepting assignment. Assignment hospitals would be given adjustments to their fixed prices to provide either a return on equity (for investor-owned hospitals) or a capital maintenance allowance (for nonprofit hospitals). Assignment hospitals also having high Medicare and Medicaid volume would receive a further price adjustment. Nonassignment hospitals no longer would receive Medicare payment for bad debts related to copayments and deductibles, and would be subject to more stringent utilization review.

Community attitudes toward nonassignment would heavily influence hospitals' decisions, as would beneficiaries' subsequent use of nonassignment hospitals. Based on a quick telephone survey, we estimate that roughly 75 percent of nonprofit hospitals would accept assignment. As Medicare changes inexorably from an open-ended program to a program with recognized financial limits, and as other payers begin to vigorously resist the traditional shifting of Medicare short falls, Congress must recognize that some beneficiaries will have to accept more of the payment burden. In our system, beneficiaries would know in advance if a hospital had accepted assignment, and the patients' liability would be limited. We anticipate that private insurance will quickly become available to cover the limited nonassigned costs.

The nonassignment option would permit hospitals to remain in the Medicare program without suffering the financial consequences of payment shortfalls; otherwise some institutions would be forced out of the program.

CBO estimates that 90 percent of hospitals would accept assignment, which led it to estimate a somewhat higher cost attributable to the return on equity/capital maintenance provision. We believe our estimate is more realistic. The earlier version had included a five-day payment cycle for assignment hospitals, which would have drawn about $1 billion forward from fiscal year 1984 into fiscal year 1983. We dropped that feature in the interest of fiscal year 1983 savings.

Controlling utilization growth is an important element of our proposal. We envision an intermediary-based utilization review system of pre-admission certification which would limit beneficiary admissions growth nationwide to 2 percent in fiscal year 1983, from an estimated 3.5 percent growth otherwise. The pre-admission certification would be applied to all nonassignment hospitals and other institutions not achieving a "deemed status." Assignment hospitals could elect a deemed status under which the hospital would administer its own certification program. Deemed status could be maintained as long as the hospital's internal program and results were effective in insuring that its admissions were medically necessary and appropriate.

CBO assumed that admissions would grow at close to the otherwise expected 3.5 percent rate. It therefore implictly rejected our estimate that HHS could implement an effective program in the short-term. We note the HHS itself proposed an intermediary-based utilization program in its fiscal year 1983 budget. We believe that if Congress so mandates, HHS would limit Medicare admissions growth to 2 percent nationally in fiscal year 1983. We are prepared to work with the Subcommittee in refining the utilization feature of our proposal, and we believe it can be made effective for fiscal year 1983.

OTHER MEDICARE PROPOSALS

As the General Accounting Office (GAO) pointed out in a recent report,[1] prospective payment is a concept encompassing many options which can be designed to produce "almost any level of program savings." For example, payment limits under Section 223 are prospectively determined. However, as GAO warned, "there is a point when a reduction in reimbursement could adversely affect access to and/or quality of care for beneficiaries."

An article in the May 30 New York Times described the service cutbacks by hospitals in New York as a result of Medicaid payment reductions. The same could happen in Medicare.

Some in Congress are considering expansion of Section 223 payment limits to cover total hospital costs, in effect establishing a national rate-setting program. AHA strongly opposes use of Section 223 because it perpetuates and worsens arbitrary payment shortfalls. Hospitals are not rewarded for becoming most cost-efficient, because the Section 223 system is based on payment limits calculated by grouping hospitals according to superficial similarities, such as size and location. A given hospital's payment limit under Section 223 is determined less by its own actions than by other institutions with which it has no relationship.

Section 223 limits are less effective than our proposed system in stimulating long-term cost reductions. Whereas our system continues to reward a hospital for continued cost reductions, Section 223 merely forces a hospital's cost to an arbitrary limit; there is no incentive to reduce below that limit.

The classification or "grouping" of hospitals for determining payment levels, which is central to Section 223 limits, has been examined for five years by the University of Washington's School of Public Health under a contract from HHS.[2] In a letter dated June 1 to AHA President Alex McMahon, quoted here in part, the project researchers, Carolyn Watts and T. D. Klastorin, reported:

"Perhaps the strongest conclusion that can be drawn from our research is that the identification of efficient and inefficient providers . . . places for too great a burden on a hospital classification system. Even the use of sophisticated statistics and elaborate computer techniques cannot compensate for poorly measured variables, unresolved conceptual issues, and the imposition of values at every turn. To believe that an objective measure of efficiency exists in such an environment is troublesome, and to believe that this measure can be approximated by comparisons of average per case or per diem costs within groups of hospitals is much more so."

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[1] "Information on Prospective Reimbursement Systems" (GAO/HRD 82-73), May 10, 1982.

[2] HHS Contract 600-76-0143.

AHA urges this Subcommittee to reject proposals to expand the Section 223 payment limits and to focus on our proposal, which holds out the promise of lasting change in hospital cost performance and Medicare cost growth. The magnitude of this year's likely change in Medicare marks a turning point in the history of the program. We are ready to work with you to help make that change in the right direction.

STATEMENT OF JAMES L. MOOREFIELD, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY BURTON E. BURTON, SENIOR VICE PRESIDENT OF AETNA LIFE & CASUALTY

Mr. MOOREFIELD. I am James Moorefield, president of the Health Insurance Association, a trade association representing some 345 of the commercial insurance companies writing health insurance coverage in this country.

With me is Mr. Burton, senior vice president of the Aetna Life & Casualty.

I, too, have filed a statement, and I will summarize and make several references to it.

The HIAA has for many years been deeply concerned about the health care cost increases in this country, as have many other groups.

We have long endorsed a variety of health care payment reform measures—legislative proposals as well as voluntary initiatives. More and more our member health insurance companies are incorporating cost reducing incentives into their benefit plans, and are paying more attention to medical necessity in their claims review process.

Despite the health care cost containment efforts of all concerned parties, the rise in health care costs continues at an alarming rate. The current health cost situation is critical. In 1981, hospital prices went up by 17 percent—almost double the increase in the CPI.

The fact is that the situation is worse than this figure indicates. Increases in the daily rate charged by hospitals—which is what the CPI measures—understates the real problem. Because of changing patterns of utilization, and the cost shifting by hospitals to make up for cuts in medicare, medicaid, and increased bad debts, the real rate of increase in health-related costs to the Nation's businesses is much higher than 17 percent.

Business will tell you that its cost of providing coverage for health care has been increasing in the order of 25–30 percent in each of the past several years. These increases are the fastest growing component in the cost of producing steel, refrigerators, automobiles, et cetera, and help make U.S. products increasingly less competitive with foreignmade goods.

The cost shift phenomenon—I don't think I have to explain that to you, because it has been referenced all day.

We estimated the cost shift at $4.8 billion in 1981.

We expect it to jump to $5.8 billion this year—a billion-dollar increase in 1 year in what we have come to call a hidden tax on consumers, on business, and all of us.

There is no one villain responsible for the dilemma. All of us—providers, consumers, insurers, and government—have all contributed to runaway inflation.

There are other various and complex reasons compounding the Nation's health care cost problems, but our purpose in appearing at this hearing is not to belabor the problems but to address solutions.

We are very much aware of the budget problems now confronting the Congress. This awareness has urged us on in our own quest for solutions. We appreciate that you—the Members of Congress—must face such critical issues as containing the Nation's health care costs while assuring that access to quality care for the Nation's elderly and needy citizens—for all Americans—is continued. Your challenge is also the challenge of the health insurance industry.

We have reviewed the so-called competition proposals as well as the other approaches for prospective payment systems such as the proposals from the hospital groups and the labor groups, and we would like to compliment both of these groups for being forthright enough to come forward with a prospective payment plan, even though the AHA proposal is limited to medicare only.

The HIAA offers its package of four proposals with a true sense of urgency and with the confidence that cost savings will be realized by the Government, employers, and consumers and that all Americans can be assured of continued access to the highest quality health care.

Our proposals blend several elements—a little regulation, a little nudging, some incentives to increase cost containment efforts and a larger role for health insurers in fighting rising health costs. We stress, however, that we are flexible and eager to discuss revisions or examine alternatives to our plan.

Our proposals are as follows:

One, appointment of a Presidential Commission on Health Care Payment Reform to make specific recommendations to Congress within 1 year.

Two, Federal legislation to allow insurers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders.

Three, establishment of State prospective payment systems to predetermine approved hospital revenues, encourage cost containment and permit all payers—government and private—to pay hospitals on an equitable basis.

Four, temporary, short-term, State-by-State limits on permissible hospital revenue increases, with penalties for hospitals in those States which exceed their limits.

This is a way to get the States to act. The question was asked earlier this morning.

States with approved prospective payment systems—voluntary or mandatory—would be exempt from these limits.

I would like to note, however, in the spirit of being flexible, that we could support other alternatives, such as the American Hospital Association's recently announced proposal, if modified to cover all payers—not just medicare—and also if modified to apply to aggregate hospital revenues.

We could support consideration of still other alternatives, such as a case mix reimbursement-type of payment plan, with payment based on predetermined charges for specific diagnoses, regardless of length of hospitalization or extent of services provided. This type of program is better known as the diagnostic related groupings—DRG—plan and is currently in place in New Jersey and proving effective. This approach is under close scrutiny by the Department of Health and Human Services.

In my written statement, I suggest three other proposals which the HIAA would not oppose; and which could be acted upon immediately to reduce medicare expenses. I will not belabor them other than to note that our estimates predict a savings to medicare of $1.3 to $1.5 billion in its first year.

There are some witnesses to follow who will say this is not the Nation's problem; that it is just a medicare-medicaid problem, and that is all you need to address.

We respectfully submit that this is a National problem. It involves every citizen of this country, the Congress, and all of the industries in the health-care field.

I would respectfully request that the summary of our proposals be included in the record at this point.

[The prepared statement and health care payment reform package follow:]

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA PRESENTED BY JAMES L. MOOREFIELD AND BURTON E. BURTON

My name is James L. Moorefield. I am President of the Health Insurance Association of American—the HIAA—a trade association representing 345 commercial health insurance companies. With me today is Burton E. Burton, Senior Vice President of Aetna Life and Casualty.

The HIAA has for years been deeply concerned about health care cost increases. We have long endorsed a variety of health care payment measures—legislative proposals as well as voluntary initiaties. Our member health insurance companies more and more are incorporating cost incentives into their benefit plans, and paying more attention to medical necessity in their claims review process.

Despite the health care cost containment efforts by all of the concerned parties, the rise in health care costs continues at an alarming rate. The current health cost situation is critical. In 1981, hospital prices went up by 17 percent—almost double the increase in the CPI.

The fact is that the situation is worse than this figure indicates. Increases in the daily rate charged by hospitals—which is what the CPI measures—understates the real problem. Because of changing patterns of utilization, and the cost shifting by hospitals to make up for cuts in Medicare, Medicaid, and increased bad debts, the real rate of increase in health related costs to the nation's businesses is much higher than 17 percent.

Business will tell you that its cost of providing coverage for health care has been increasing in the order of 25-30 percent in each of the past several years. These increases are the fastest growing component in the cost of producing steel, refrigerators, automobiles, etc., and make U.S. products increasingly less competitive with foreign made goods.

The cost shift phenomenon—which I'm sure you have all heard about is of particular concern to our industry. The cost shift results when government increasingly refuses to pay hospitals the full cost of providing care to Medicare and Medicaid patients, and hospitals, in order to cover such shortfalls in revenues must increase its charges to private sector patients.

The HIAA estimated the cost shift at $4.8 billion in 1981. We expect it to jump to $5.8 billion this year—a billion dollar increase in one year in what we have come to call a hidden tax on consumers, on business, and all of us.

There is no one villian responsible for the dilemma. All of us—providers, consumers, insurers, and government—have all contributed to runaway inflation.

There are other various and complex reasons compounding the nation's health care cost problems, but our purpose in appearing at this hearing is not to belabor the problems but to address solutions.

We are very much aware of the budget problems now confronting the Congress. This awareness has urged us on in our own quest for solutions. We appreciate that you—the members of Congress—must face such critical issues as containing the nation's health care cost yet assuring that access to quality care for the nation's elderly and needy citizens—for all Americans—is continued. Your challenge is also the challenge of the health insurance industry.

We have studied the recent proposals made by the American Hospital Association and by the labor groups Health Security Action Council with a great deal of interest. We compliment each of these organizations for coming forth with prospective payment proposals, even though the AHA proposal is limited to Medicare payments.

The HIAA offers its package of four proposals with a true sense of urgency and with the confidence that cost savings will be realized by the government, employers and consumers and that all Americans can be assured of the continuance of access to the highest quality of health care.

Our proposals blend several elements—a little regulation, a little nudging, some incentives to increase cost containment efforts and a larger role for health insurers in fighting rising health costs. We stress, however, that we are flexible and eager to discuss revisions or examine alternatives to our plan.

Our proposals are as follows:

1. Appointment of a Presidential Commission on Health Care Payment Reform to make specific recommendations to Congress within one year.
2. Federal legislation to allow insurers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders.
3. Establishment of state prospective payment systems to predetermine approved hospital revenues, encourage cost containment and permit all payers—government and private—to pay hospitals on an equitable basis.
4. Temporary, short-term, state-by-state limits on permissible hospital revenue increases, with penalities for hospitals in those states which exceed their limits. States with approved prospective payment systems—voluntary or mandatory—would be exempt from these limits.

In addition, the HIAA could support other alternatives, such as the American Hospital Association's recently announced proposal, if modified to cover all payers—not just Medicare—and also, if modified to apply to aggregate hospital revenues.

We could support consideration of still other alternatives, such as a case mix reimbursement-type of payment plan, with payment based on predetermined charges for specific diagnoses, regardless of length of hospitalization or extent of services provided. This type of program is better known as the Diagnostic Related Groupings (DRG) plan and is currently in place in New Jersey and proving effective. This approach is under active consideration by the Department of Health and Human Services.

I would also like to point out to the Committee that there are some other practical, immediate steps to reduce Medicare program costs which we do not oppose.

We would support bringing all federal employees under the Medicare system.

We do not oppose making Medicare secondary to employee group insurance for workers over age 65, nor do we see any practical problems with delaying the initial eligibility date for Medicare beneficiaries.

In conclusion, Mr. Chairman, some will tell you that the problem of rising health care costs is not the nation's problem, only the federal government's problem. The solutions they propose would reduce the federal government's payments and let the hospitals make up the shortfall wherever they can, from private patients, from Medicare beneficiaries, and by increases in charges to other payers.

We believe the problem is indeed one that affects the entire nation. Continued cost increases in the magnitude of what we are now experiencing is damaging the financial viability of the nation's hospitals which continue to serve the poor and the elderly; is causing serious dislocations in the private insurance industry; is causing political havoc for state and federal governments; and, most importantly, is driving up the costs of this nation's goods and services and thus affecting our ability to compete in the international economy.

We thank you for the time given us to present our proposals and will appreciate your consideration of our package for reform.

Mr. Chairman, I ask that a background statement and a summary statement of the HIAA Health Care Payment Reform Package be included in the record at this point as part of my statement.

THE INSURANCE INDUSTRY AND HEALTH CARE PAYMENT REFORM: A BACKGROUND STATEMENT

The Health Insurance Association of America (HIAA) has long endorsed health care payment reform.

In the late 1970s, the HIAA supported enactment of legislation to create state regulatory agencies which would review hospital budgets on a prospective basis and approve charges for all patients, regardless of the source of payment.

This action flowed out of the basic principle for a "Health Care in the 1980s" program approved by the HIAA, which stated: "The present health care system should be retained, but it should be modified so as to facilitate the containment of rapidly escalating costs and improvement in the delivery of care."

In 1979 the HIAA was one of the few organizations to support President Carter's bill to place a mandatory cap on hospital revenues, which included exemptions for those states which had adopted effective cost containment proposals.

The rationale at the time may be summed up thusly: the usual marketplace forces of supply and demand are absent in the hospital industry as the physician rather than the consumer determines the type and extent of services; state prospective payment systems are more successful containing costs than voluntary efforts; prospective payment programs can provide incentives for achieving economies in the system and can bring about other improvements in financial planning and utilization review; and they can reduce or eliminate the cost shifting problem.

Despite the defeat of the Administration's proposal, the policy of the HIAA in 1980 was to support federal funding and encouragement for state hospital prospective payment systems which met federal guidelines, including equity of reimbursement.

However, the environment began to change when the Reagan Administration came into office. Prospects dimmed for equitable cost containment legislation because of the trend toward deregulation and the cut-back of government programs as a means of reducing the federal budget deficit.

At the same time, increasing emphasis was being placed on voluntary approaches to health cost containment, such as the Voluntary Effort of the health professions and the emergence of health care coalitions in states and communities across the country.

Against this background, the HIAA re-examined its policy and determined to stress voluntary initiatives to contain health care costs and achieve equity among all payers.

Progress has been achieved. Consumers and the business community are today better informed and more concerned about health cost inflation. Greater efforts are being made by health providers to improve productivity and efficiency. Health insurers more and more are incorporating cost saving incentives in benefit plans—such as coverage of pre-admission testing, second opinions for elective surgery, and outpatient surgery—and focusing more closely on medical necessity in their claims review. And great interest is being demonstrated in the health care coalition movement.

Despite these measures, however, the rise in health care costs persists and is further complicated by the serious and growing shift of Medicare costs to private patients.

In response, the health insurance industry has undertaken a nationwide public information program to alert the public and urge solutions to these problems.

Further, after extensive study, the HIAA has determined that voluntary approaches are no longer sufficient to cope with health cost inflation and the persistent increase in cost shifting. The Association believes that the key to effecting health cost containment and equity of payment lies within the states and accordingly has developed a Health Care Payment Reform package composed of the following solutions:

1. A Presidential Commission on Health Care Payment Reform should be appointed to develop an equitable payment system for all payers of medical services.
2. Federal law should be amended to allow insurers to negotiate jointly with health care providers with respect to cost and utilization of services and to share and utilize data to contain costs.
3. States should set in place hospital prospective payment systems to achieve health care cost containment and provide equity of payment among all payers.
4. Consideration should be given to other alternatives, such as Diagnostic-Related Groupings (DRG) type of reimbursement plan, such as is now in place in New Jersey, provided the plan will not increase hospital cost shifting. Under DRG, payment is made on the basis of predetermined charges for specific diagnoses.

5. Limits should be imposed as soon as possible on aggregate hospital revenues for a period of no longer than four years.

6. Endorsement should be given to the concepts of the American Hospital Association's predetermined fixed price payment plan for Medicare and Medicaid patients, applied on a per-discharge basis, if modified to include all payers.

HEALTH INSURANCE ASSOCIATION OF AMERICA HEALTH CARE PAYMENT REFORM PACKAGE—A SUMMARY

The inflation rate in the nation's health care costs is out of control. Health insurers are concerned. The health care consumer and the employer who provides health benefits are concerned. For years insurers have supported an array of cost containment programs. However, in the face of the continuing cost crisis the Health Insurance Association of America developed a new package of proposals which seeks to control health care cost inflation.

Included among these proposals is the concept that all payers—Medicare, Medicaid, Blue Cross, commercial insurers, self-insuring employers and self-paying patients—Must pay hospitals on a fair and equitable basis.

The specific proposals are:

1. Appointment of a Presidential Commission on Health Care Payment Reform to make specific recommendations to Congress within one year.

2. Federal legislation to allow insurers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders.

3. Establishment of state prospective payment systems to predetermine approved hospital revenues, encourage cost containment and permit all payers—government and private—to pay hospitals on an equitable basis.

4. Temporary, short-term state-by-state limits on permissible hospital revenue increases, with penalties for a hospital whose revenues exceed its portion of these limits. States with approved state prospective payment systems—voluntary or mandatory—would be exempt from these limits.

In addition, the HIAA could support other alternatives, such as the American Hospital Association's proposal, if modified to cover all payers—not just Medicare and Medicaid—and if modified to apply to aggregate hospital revenues. The HIAA could also support consideration of still other alternatives, such as a Diagnostic-Related Groupings (DRG) or other case mix reimbursement type of payment plan, with payment based on predetermined charges for specific diagnoses, regardless of length of hospitalization or extent of services provided.

HEALTH INSURANCE ASSOCIATION OF AMERICA PROPOSAL FOR HEALTH CARE PAYMENT REFORM—THE CURRENT CRISIS

Despite a receding level of overall inflation, health care costs continue to mount. In 1981 these prices rose 13 percent, with hospital prices alone going up by 17 percent. In contrast, prices for all goods and services went up by 8.9 percent. The nation's total health care bill last year soared to $275 billion, or 9.6 percent of the Gross National Product.

The Department of Health and Human Services predicts that by 1985 at the present rate of increase, health care spending will consume 10 percent of our GNP.

Medicare expenditures alone, according to government estimates, will triple by 1990, rising to $150 billion. Congress views Medicare expenditures as a major part of the problem of the federal budget deficit, which is estimated to rise as high as $180 billion in 1983, unless present law is changed.

Efforts by the private sector and government to contain health care costs are being undermined by the serious and growing problem of health care cost shifting. Hospitals are making up losses incurred from inadequate Medicare and Medicaid reimbursements by increasing charges to all other patients.

The HIAA estimates that the amount of the cost shift—which totaled $4.8 billion in 1981—will rise to $5.8 billion in 1982 if no action is taken. Without a solution to cost shifting, true health care cost containment cannot be achieved. Hospitals today have an incentive to shift costs instead of cutting costs.

PROPOSAL FOR HEALTH CARE PAYMENT REFORM

There is agreement by all parties that the status quo is unacceptable. Urgent measures are needed to develop solutions to health cost inflation and the burden of cost shifting while maintaining the continued high quality of health care.

The Health Insurance Association of America (HIAA) proposes the following:

1. Appointment of a Presidential Commission on Health Care Payment Reform to make specific recommendations to Congress within one year.

Such a body should be composed of representatives of the business community, private health insurance, labor, health care providers, and the federal and state governments. It would be required to report its findings within a 12-month period.

The Commission could be a major step forward toward bringing about a new, fair and equitable reimbursement system and in the process solve the problem of cost shifting among the nation's hospitals.

2. Federal legislation to allow insurers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders.

Because of anti-trust considerations, private health insurers have been unable to act jointly on cost containment activities. The HIAA accordingly seeks Congressional relief in order to achieve greater effectiveness in these health cost containment efforts.

3. Establishment of state prospective payment systems to predetermine approved hospital revenues, encourage cost containment and permit all payers—government and private—to pay hospitals on an equitable basis.

States which have instituted prospective payment programs have exhibited a rate of increase in hospital expenses significantly below the nationwide rate. They are providing incentives for achieving economies in the health care system. They are bringing about other improvements in hospital financial planning and utilization. Prospective payment programs can eliminate the problem of hospital cost shifting.

4. Temporary, short-term state-by-state limits on permissible hospital revenue increases, with penalties for a hospital whose revenues exceed its portion of these limits. States with approved state prospective payment systems—voluntary or mandatory—would be exempt from these limits.

The purpose would be to bring health care costs under control and stem the cost shifting tide over the short term, thus allowing sufficient time for the Commission to conceive innovative approaches to health care payment reform and for Congress and the Administration to implement such reforms.

Separate revenue limits would be set for each state based upon guidelines established by the federal government. These limits would apply to inpatient services rendered to all patients, regardless of payer.

The proposed revenue limit would be set at a designated percentage of the ongoing five-year average of hospital revenue increases. Hospitals within a state failing to live within the limits would be required to reduce future patient charges by the amount of excess revenues collected in the prior 12 months. The cap would provide hospitals with a strong incentive to initiate effective cost containment efforts as quickly as possible.

To spur state action, those states which already have effective hospital prospective payment programs in place—such as Maryland and New Jersey—would be exempt from the federal program, as would any state program initiating a qualified voluntary or mandatory program. These programs provide positive incentives for reducing overall hospital cost escalation and generate significant savings for both private and government programs.

The incentives result because such a system determines in advance needed hospital revenues which will form the basis of payment by all patients. For example, under the Maryland-style system, hospitals cannot shift costs, nor can they raise charges without state agency review.

In this way, hospitals are encouraged to achieve savings by increasing their operating efficiency. In short, they will recognize that increased efficiency will produce an operating surplus.

This surplus can be used at the hospital's discretion for new programs, services and modernization. Or it may simply be contributed to a hospital's reserves to help assure the institution's financial stability.

In the states that adopt their own qualified voluntary or mandatory program, Medicare could not be required to pay more than it otherwise would have paid under the present system.

In addition, the HIAA could support other alternatives, such as the proposal of the American Hospital Association, if modified to cover all payers—not just Medicare and Medicaid—and if modified to apply to aggregate hospital revenues.

Other features of the AHA approach which the HIAA supports include:

A forecasted price index to keep hospital cost increases closer to increases in prices generally.

Incentives available to encourage hospitals to: (a) participate in regional health planning and cooperative capital expenditure projects; (b) accept Medicare and Medicaid reimbursement as payment in full; and (c) continue to treat a high volume of Medicare and Medicaid patients.

An appeals process to adjust hospital rates for extraordinary circumstances.

Utilization review for all patients.

Exemptions for all states with prospective budget- or rate-setting programs, as well as waivers for alternate prospective payment approaches initiated in the states.

The HIAA could also support consideration of still other alternatives, such as a Diagnostic-Related Groupings (DRG) or other case mix reimbursement-type of payment plan, with payment based on predetermined charges for specific diagnosis, regardless of length of hospitalization or extent of services provided.

Such a program is now is effect in New Jersey and is proving effective. However, before formally endorsing this approach, the HIAA will assess whether or not DRG would increase the hospital cost shift.

A DRG plan is under active consideration by the Department of HHS for Medicare and Medicaid patients.

THE MARYLAND-NEW JERSEY MODELS

Enabling legislation in Maryland and New Jersey gives hospital rate-setting authorities jurisdiction over rates paid by all private sector patients. In addition, these authorities have obtained approval from the federal and state governments to establish comparable rates for Medicare/Medicaid payments. Such approval was obtained under Section 222 of the Medicare/Medicaid amendments of 1972. This section allows the Secretary to waive the usual reimbursement regulations in order to experiment with prospective payment systems.

By participating in the waiver system, Medicare and Medicaid agree to reimburse for centain services they would not otherwise pay. In effect, therefore, they pay on the same basis as private insurers.

It should be pointed out that a waiver includes inside limits on the government's liability. In other words, Medicare/Medicaid expenditures would not rise above the level they would reach without the program in effect. Operating with a Medicare/Medicaid waiver, Maryland has achieved both equity among payers and government payments that are at least as low as they would have been in the absence of the program. Here are data showing that the savings in Medicare/Medicaid in Maryland over a three year period totaled $86.5 million.

SAVINGS IN MARYLAND

[In millions]

Year	Medicare	Medicaid	Total
1978	$15.2	$8.0	$23.2
1979	17.6	12.1	29.7
1980	19.8	13.8	33.6
Total savings			86.5

Source: Maryland Health Services Cost Review Commission.

RESOLVING THE PROBLEM IN THE PUBLIC INTEREST

There is broad agreement that the status quo is unacceptable. Though there may be difficulties in implementing corrective action—and even a lack of unanimity on the best option—the future stability of the health care system demands that health care cost problems be recognized, addressed, and resolved in the public interest.

Chairman JACOBS. Without objection, that material will be included in the record.

Mr. Gradison has no questions.

Mr. Holland.

Mr. HOLLAND. Thank you, Mr. Chairman.

I gather from your statement you support capping hospital revenues?

Mr. **Moorefield**. Only as a last measure and only for a temporary period. We believe that there are other solutions through prospective payment systems which we are proposing be studied.

Mr. **Holland**. Would you support caps on health insurance premiums?

Mr. **Moorefield**. Our insurance industry is highly regulated. Our premiums do have to be justified by experience. Particularly in the group field our premiums reflect the pass-through of the cost experience of this Nation's employers. We believe we are regulated already. We believe that stiff competition further regulates us.

Mr. **Holland**. Do you put limits on what you will pay for various services covered under your policies?

Mr. **Moorefield**. We do have deductibles available. We do have coinsurance provisions that are available, and maximums in certain cases that are available.

Mr. Burton.

Mr. **Burton**. Beyond that, the coverage provided is really quite comprehensive and covers the general range of services that medicare would provide coverage for.

Mr. **Holland**. It just pays what the provider of the service charges, in effect, doesn't it?

Mr. **Burton**. We do not routinely pay what the provider of service charges. In terms of the type of service that is rendered, almost anything that one could think of as a typical service is generally covered under these plans.

Mr. **Holland**. Do you have any program in your association dealing with utilization review?

Mr. **Moorefield**. We are supporters of utilization review. We do not have as such in our association, however, our member companies do carry out utilization review programs through contractors, and we are trying to get more of that. We have been a proponent of it.

Mr. **Holland**. I am trying to get an understanding of this problem.

We are talking about a Federal thrust into medical costs and Federal regulation of almost everything but your industry, which is State regulated.

The logical question is, why shouldn't Congress repeal the McCarren-Ferguson Act and impose Federal regulation on the insurance industry?

Mr. **Moorefield**. That is always a possibility, but we are submitting that we are regulated now, and we are not looking to regulate any other industry.

We are reluctant to come forth with any regulation on another industry.

We feel the time is urgent to take action, and we are willing to talk, willing to negotiate with anyone; but we have to address the current situation we are now in.

Mr. **Holland**. Nothing in your program really affects the day-today business of your members, though. It does not change it from what it is right now. You are simply suggesting that you will make changes in other areas of health service?

Mr. **Burton**. Correct.

Mr. **Holland**. That is correct.

Mr. **Moorefield**. It would not change our financing.

Mr. **Holland**. If you didn't pay for them, the services would not be provided in most cases, so you are an integral part in all of this.

It is like some of our tax legislation around here; we have every group coming in here and saying, tax everybody else, and now you come in and say, regulate everybody else.

Mr. **Moorefield**. If there was any other way to get our other three proposals advanced, this would be the last one we would want to push.

This is our approach. There needs to be some carrot that will encourage States to act. Last year, in the reconciliation bill the conference committee adopted a financial incentive for those States that operated a prospective payment system. Those States would be given one-half of 1 percent extra in medicaid reimbursement.

Unfortunately, in the conference committee they also put in a deadline on it, thereby limiting the number of States who could qualify to those which already had reimbursement systems.

If a one-half of 1 percent carrot is enough to get more States to act, we recommend that you get rid of that July 1, 1981, deadline.

Mr. **Holland**. Would you support the concept of prospectively determined premiums?

Mr. **Moorefield**. Yes, sir.

Mr. **Holland**. Are they in every State?

Mr. **Moorefield**. They are, sir. That is the reason our companies are losing so much money in these last few years.

Mr. **Holland**. Federal regulation of your industry would apply on a Federal level?

If we did move into Federal regulation of your industry, we would be talking about prospectively determined premiums?

Mr. **Moorefield**. As they are now, sir.

Mr. **Holland**. Thank you very much.

Chairman **Jacobs**. Gentlemen, we thank you for your contribution, and the committee will study your proposals.

The next panel consists of the Association of Volunteer Trustees of Not-for-Profit Hospitals, John Sinn, chairman; The American Association of Retired Persons, James M. Hacking, assistant legislative counsel; and William R. Hutton, executive director, National Council of Senior Citizens.

We have arrived at that place on the schedule where the 5-minute rule obtains, I am told.

I will renew the practice of the subcommittee of offering a reward of a silver dollar for the person who speaks most concisely, and half a dollar for the person who comes in second.

STATEMENT OF JOHN L. SINN, CHAIRMAN, ASSOCIATION OF VOLUNTEER TRUSTEES OF NOT-FOR-PROFIT HOSPITALS

Mr. **Sinn**. I am John Sinn, and I am a trustee of Eisenhower Medical Center in California. I am chairman of Volunteer Trustees of Not-for-Profit Hospitals, a nationwide organization of hospital trustees.

All of us are gathered here because we recognize that the medicare trust funds are hemorrhaging. There is not time now to determine why they are hemorrhaging. Commonsense dictates that we stop the hemorrhages first. There will be time later to discuss long-range cures, including permanent rearrangements in reimbursement formulas.

I must say to you that it is my hope and conviction that we will not reduce services for the elderly. Kidney dialysis may be a nearly $2 billion expense, but surely we cannot return to those days—not so long ago—when a panel decided who was to receive the treatment or who must die without it.

Nor can we make those decisions about the heart bypass. Total hip replacements, the technique of angioplasty, and all those other lifesaving, life-lengthening, life-quality-giving procedures that were not dreamed of when medicare and medicaid were born.

Yet we agree that we must check this increasing outpouring of moneys that threatens the whole system. The method that is proposed by the organization I represent, Volunteer Trustees of Not-for-Profit Hospitals, is simple, bold, effective, and quick. It can be done almost instantly. It is in a tradition that has been long favored by Americans.

Very simply, our plan says let those medicare patients who are more affluent pay a larger deductible. All medicare patients currently pay a deductible. Put a floor—we suggest an adjusted gross income of $25,000—before such increases in deductibles begin. And then we propose to index those deductibles so that the higher the income, the higher the deductible. And we would do the same for the coinsurance payment and the part B premium.

The so-called medicare safety net remains securely in place for the poor, the indigent and the less affluent. And medicare remains in place, too, for those more fortunate, serving as an umbrella for those major health costs that burden even them, but requiring that they pay a bit more if their income is higher, and then a bit more if that income increases, and so on.

Gentlemen, accepting this principle for medicare, as we long ago accepted it for income taxes, will mean a $3 billion saving in 1983 and even more in succeeding years.

Does it take political courage to make even this small and fair inroad on a so-called sacred entitlement program? Perhaps, but the alternative of reducing care for the aging, eliminating lifesaving service for some may well be political suicide. Make no mistake. That's where we are headed. Medicare, which started as a cost-plus-reimbursement program, is now a cost-minus program.

I beg of you, do not make the error to believe there is enough waste in the system to save the moneys you need. Like everything else in our society, there are, I am certain, hospitals who could be more efficient; doctors who could charge less.

Go after them, by all means; make this health delivery system as perfect as we can. We are ready to suggest other means to you as well for saving medicare funds.

But here, today, in this emergency, under the time restrictions you have imposed upon us for testifying, we urge you to thoughtfully consider this very simple proposal for indexing medicare deductibles.

We have submitted formal testimony and a draft bill for the record.

STATEMENT OF VOLUNTEER TRUSTEES OF NOT-FOR-PROFIT HOSPITALS PRESENTED BY JOHN L. SINN, CHAIRMAN

Mr. Chairman and members of the subcommittee, I am John L. Sinn. I am a Trustee of the Eisenhower Medical Center in California and Chairman of Volunteer Trustees of Not-for-Profit Hospitals on whose behalf I am here to testify today. We share your deep concern for the future of the Medicare program. And we are gratified by this indication that your Subcommittee is looking at structural reform—recognizing the need for major revision of a program with whose merits we all still concur. The problem is fiscal solvency; to reform without losing the parts that work so well. Medicare has met much of the promise it made to the elderly two decades ago—and at issue now is how we can keep it.

Basically, the options from which we have to choose are two: we can decrease expenditures of the program by severely cutting back on what Medicare pays to providers for medical services; or we can increase revenues by implementing further taxes or cost-sharing among the beneficiaries.

Let us not labor under the delusion for one minute that cutting reimbursement to providers will not cut medical services to beneficiaries. We hear over and over that cuts and revenue caps will promote "efficiency"—that is pie-in-the-sky logic; a wish-filled correlation. Cuts will promote quotas, waiting lines, and Medicare referrals. It will assure lists for hip replacements, limits on Medicare beds, and the minimizing of Medicare census.

Make no mistake about Medicare cutbacks: they would simply commute decisions about the entitlement to medical care from the shoulders of Congress to the shoulders of the individual hospital. It is the Medicare cuts currently contemplated by Congress that truly threaten this entitlement program.

As to the second option, that of increasing revenues, this seems an extraordinary burden on a population which is already contributing substantially to the cost of care. As you well know, Medicare patients pay high out-of-pocket costs for physician services. In addition they pay $254 on their first day of hospitalization, and a high co-payment on days 61-90 if they should be so unfortunate—and needy—as to stay in the hospital for a long period of time. This for a retired, elderly person living on social security or even with a moderate income is a sizable burden, a substantial proportion of his income—and can total more than $10,000 per year. Increasing this contribution would hard press the overwhelming majority of the nation's elderly dependent on Medicare for their medical care.

However, to the retired person with an expendable income of $30,000 per year—or $50,000—or $100,000; the required deductible, premium, and co-pay are felt much less; they are not sacrifice, and in the top income categories they are only a minuscule proportion of income. It seems so logical that these high income participants—about 8 percent of the elderly population—should be required to contribute to the Medicare program in a manner similar to middle and lower income groups. We are simply suggesting that instead of retaining the regressive structure of the Medicare pay schedule, we index the contribution in accordance with one's ability to pay. This proposal to index the premium deductible and co-payment among the wealthy has the following benefits:

It is simple, and easy to implement and administer. It keeps the medical benefit package of Medicare intact. It is consistent with current thinking on the deterrent utilization value of cost-sharing. It is compatible with whatever other reform we bring to the health care field at large, from voucher systems in an increased competitive environment to prospective rate setting to broader state and federal regulatory schemes. It can be instituted with a minimum of delay for fiscal year 1983. And, most important—this proposal according to CBO estimates would save $3 billion in the first year. None of this would come out of the pockets of middle and low income Americans.

I should add that we have come to recognize the shock value of this proposal. People fear that it negates the entitlement concept, or that "means testing" Medicare (that trigger phrase) sound like welfare and has no political viability. Let us be clear on this subject; we are not proposing that we change the entitlement—all who are entitled presently would continue to be; all benefits to which we are currently entitled would remain in place. The entitlement would in no way be tied to income.

We already pay a deductible premium and co-pay, and we are merely recommending that it not be uniform—but indexed in the upper brackets. This proposal would not alter the real benefits—i.e., medical services—available to the elderly under Medicare. It seems that after consideration of the realities and the options, the public would likely embrace such a proposal ready to recognize the need for change in times of such overwhelming fiscal pressure.

We have submitted for the record a draft bill for your consideration which attempts to deal with the detail of such an indexing proposal. It is simply a recommendation that may well need refinement, but it demonstrates that this can work—quickly and with minimal administrative delay.

To briefly summarize, our proposal would:

Index the Medicare hospital insurance deductible and coinsurance and the Medicare Supplementary Medical Insurance (SMI) premium (Part B) in income categories over $25,000 AGI. This would save $3 billion in the first year.

Medicare patients currently pay $260.00 on day one of hospitalization. We would increase this deductible for beneficiaries with AGI over $25,000.

Medicare patients currently pay $65.00 on hospital days 61–90. We would index co-pay for patients in the upper income bracket only; and move that co-pay to day one.

Medicare recipients currently pay $11.00 for Part B premium. We would increase that premium for beneficiaries with AGI's over $25,000.

The following things are what this bill would not do:

It would not change the medical care benefits in any way, nor alter the entitlement.

It would not change anything in any way for beneficiaries with AGI less than $25,000 per annum.

It would not change anything for any disabled person eligible for Medicare under OASDI.

In summary, then, let me say that it is clear to us all that structural reform of Medicare is necessary in order to continue to offer such a program to the nation's elderly.

We are convinced that this proposal truly offers a solution to this most difficult problem in which we are all involved together. We pledge to support and assist in whatever action you take to bring this about, as we remain, with you, committed to saving the Medicare program.

And finally, in conscience, I cannot leave the hearing without speaking to the issue of funded depreciation—which you've all heard so many times. The backbone of our nation's hospital system is the not-for-profit hospitals: community, teaching, rural or urban, small or large. It is the well-spring of medical advance in education, training, research, technological development and improvements in quality of life. And too, it is the testament to our best selves: to philanthropy, charity and community self-help. Without the ability to sustain itself, this hospital system is nothing, and what we would lose, through short-sighted legislative action, is of value beyond description. The most serious issue underlying cutbacks in Medicare reimbursement boils down to this: the voluntary hospitals can't continue to care for their communities if they can't afford to keep their doors open. Funding depreciation and accruing replacement potential are basic and necessary.

SUMMARY OF PROPOSED LEGISLATION TO INDEX MEDICARE DEDUCTIBLES AND CO-PAYMENTS PART A AND PREMIUMS PART B

Proposed Title: "Medicare Financing Improvements Act of 1982."

This bill would index to adjusted gross income the Medicare hospital insurance deductible and co-insurance, and the Medicare supplementary medical insurance (SMI) premium. The purpose of the bill is to strengthen the financial viability of the Medicare Trust Fund without cutting back services to beneficiaries. The bill seeks to more evenly distribute the burden of the financial contribution among levels of income in recognition of the fact that it currently weighs most heavily on the lower income participants.

Under Part A, deductibles for persons earning more than $25,000 AGI would range from $500 to $3,000 over $75,000 AGI. This deductible is roughly 2 percent of the income at the bottom of each bracket. In addiition, participants with incomes over $25,000 would pay a co-payment for days 2–60 of $10 to $100 per day indexed to income.

Under Part B, the premium price for participants with incomes over $25,000 AGI would range from 50 percent to 100 percent of the per capita annual outlay.

These changes effect only persons in the upper income brackets. This is no change in deductible, co-pay or premium for those in middle and lower

The attached page indicates proposed income brackets matched with deductible, co-pay and premium. Maximum expenditures, for persons with AGI over $75,000 and with more than 60 consecutive days of hospitalization, would not exceed $9,590.

CBO stimate indicate that 1983 savings would total $1.6 billion for part Part B to nearly $2 billion for Part A.

Adjusted gross income brackets	Part A deductible [1]	Part A co-pay per day [2]	Part B premium (percent) [3]
$25,000 to $29,999	$500	$10	50
$30,000 to $39,999	600	25	70
$40,000 to $49,999	800	50	80
$50,000 to $75,000	1,000	75	90
Over $75,000	3,000	100	100

[1] The deductible is roughly 2 percent of the bottom of the bracket.

[2] Co-pay begins on day 2 and ends on day 60. Day 61-90, no co-pay.

[3] Percentage of the total of the benefits and administrative costs estimated payable in succeeding year as promulgated annually by Secretary of HHS.

Note.—No change from current program for disabled and beneficiaries with AGI less than $25,000.

A BILL To provide for the indexing of the Hospital Insurance deductible and coinsurance for individuals with $25,000 in adjusted gross income or more

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Hospital Insurance Financing Improvements Act of 1982".

INDEXING THE HOSPITAL INSURANCE DEDUCTIBLE AND COINSURANCE TO ADJUSTED GROSS INCOME FOR INDIVIDUALS WITH $25,000 IN ADJUSTED GROSS INCOME OR MORE

SEC. 2. (a) Section 1813(a)(1) of the Social Security Act is amended—

(1) by adding in the first sentence thereof "applicable to such individual" immediately after "deductible";

(2) by striking out subparagraph (A) thereof and inserting in lieu thereof the following:

"(A)(i) one fourth of the inpatient hospital deductible applicable to such individual for each day after the 60th but before the 91st day on which such individual is furnished such services during such spell, if the adjusted gross income of such individual is less than $25,000; or

"(A)(ii) $10 for each day before the 61st day on which such individual is furnished such services during such spell, if the adjusted gross income of such individual is equal to or greater than $25,000 but less than $30,000; or $25 for each day before the 61st day on which such individual is furnished such services during such spell, if the adjusted gross income of such individual is equal to or greater than $30,000 but less than $40,000; or $50 for each day before the 61st day on which such individual is furnished such services during such spell, if the adjusted gross income of such individual is equal to or greater than $40,000 but less than $50,000; or $75 for each day before the 61st day on which such individual is furnished such services during such spell, if the adjusted gross income of such individual is equal to or greater than $50,000 but less than $75,000; or $100 for each day before the 61st day on which such individual is furnished such services during such spell, if the adjusted gross income of such individual is equal to or greater than $75,000; and"

(3) by adding in subparagraph (B) thereof "applicable to individuals whose adjusted gross income is less than $25,000" immediately after "deductible".

(b) Section 1813(a)(3) of the Social Security Act is amended by inserting "applicable to individuals whose adjusted gross income is less than $25,000" immediately after "deductible".

(c) Section 1813(b)(2) of the Social Security Act is amended—

(1) by inserting at the beginning of the first sentence thereof "For individuals whose adjusted gross income is less than $25,000, the" and striking out "The";

(2) by inserting at the beginning of the second sentence thereof "For such individuals, such" and striking out "Such"; and

(3) by adding at the end thereof: "For an individual whose adjusted gross income is equal to or greater than $25,000, but less than $30,000, the inpatient hospital deductible shall be $500. For an individual whose adjusted gross income is equal to or greater than $30,000 but less than $40,000, the inpatient hospital deductible shall be $600. For an individual whose adjusted gross income is equal to or greater than $50,000 but less than or equal to $75,000, the inpatient hospital deductible shall be $1,000. For an individual whose adjusted gross income is greater than $75,000, the inpatient hospital deductible shall be $2,500."

(d) Section 1813 of such Act is further amended by adding thereto the following new subsection (c):

"(c) For the purposes of this subsection, "adjusted gross income" means the adjusted gross income reported on an individual's Individual Income Tax Return for his second tax year preceding the year in which the deductible is applied. In the case of an individual making a joint return for such tax year, one half of the entire household adjusted gross income reported on such return shall constitute such individual's adjusted gross income for the purpose of this subsection."

USE OF INCOME TAX INFORMATION

SEC. 3. Notwithstanding any other provision of law, the Secretary of the Treasury shall furnish to the Secretary of Health and Human Services such information as the Secretary of Health and Human Services deems necessary in order to carry out the amendments made by this Act.

EFFECTIVE DATE

SEC. 4. The amendments made by this Act shall become effective beginning with January 1, 1983.

A BILL To provide for the indexing of the Supplementary Medical Insurance premium to adjusted gross income for individuals with $25,000 in adjusted gross income or more

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Supplementary Medical Insurance Financing Improvements Act of 1982".

INDEXING THE SUPPLEMENTARY MEDICAL INSURANCE PREMIUM TO ADJUSTED GROSS INCOME FOR INDIVIDUALS WITH $25,000 IN ADJUSTED GROSS INCOME OR MORE

SEC. 2. (a) Section 1839(c)(2) of the Social Security Act is amended to read "Except as provided in subsection (e), the amount determined under paragraph (3) shall be the monthly premium of each individual enrolled in this part for each month after June 1973 but before July 1, 1983. For months after June 1983 the amount determined under pargaraph (3) shall (except as provided in subsection (e)) be the monthly premium of each enrollee age 65 and over whose adjusted gross income is less than $25,000 and the monthly premium of each disabled enrollee under age 65."

(b) The first sentence of section 1839(c)(3) of the Social Security Act is amended by adding at the beginning thereof "Except as provided by subsection (d), the" and striking out "The", and by striking out "applicable for the individual enrolled under this part".

(c) Subsections (d) through (f), inclusive, of section 1839 of the Social Security Act are redesignated as subsections (e) through (g) respectively.

(d) Section 1839 of the Social Security Act is further amended by adding the following new subsection (d):

"(d)(1) The Secretary shall, during December of 1982 and during each succeeding December, determine and promulgate the premium rates for individuals enrolled in this part whose adjusted gross income is equal to or greater than $25,000. Such premiums rates shall be applicable for the 12-month period commencing the following July 1.

"(2) To determine the premium rates applicable under this subsection, the Secretary shall estimate the total amount of the benefits and administrative costs payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs to be incurred for the 12-month period commencing the following July 1, with respect to all enrollees 65 and over. The Secretary shall than divide such total estimated amount by the total projected number of enrollees 65 and over for such a period, and divide the resulting amount by 12 to obtain the total estimated monthly cost per enrollee for such period. The Secretary shall then promulgate monthly premium rates for such 12-month period, such that the monthly premium applicable to an enrollee age 65 or over whose adjusted gross income is—

Equal to or greater than $25,000 but less than $30,000 will equal 50 percent of the total estimated monthly cost per enrollee;

At least $30,000 but less than $40,000 will equal 70 percent of the total estimated monthly cost per enrollee;

At least $40,000 but less than $50,000 will equal 80 percent of the total estimated monthly cost per enrollee;

At least $50,000 but less than $75,000 will equal 90 percent of the total estimated cast per enrollee; and

Over $75,000 will equal 100 percent of the total estimated monthly cost per enrollee.

"(3) For the purposes of this subsection, "adjusted gross income" means the adjusted gross income on an individual's Individual Income Tax Return for the most recent tax year prior to the period for which the premium is promulgated. In the case of an individual making a joint return for such tax year, one-half of the household adjusted gross income reported on such return shall constitute such individual's adjusted gross income for the purposes of this subsection."

(e) The first sentence of subsection (e) of section 1839 of the Social Security Act, as redesignated by section 2(c) of this Act, is amended by striking out "or (c)" and substituting in lieu thereof ", (c) or (d)".

(f) Section 1839(g) of the Social Security Act, as redesignated by section 2(c) of this Act, is amended by striking out "(d)" and inserting in lieu thereof "(e)".

USE OF INCOME TAX INFORMATION

SEC. 3. Notwithstanding any other provision of law, the Secretary of the Treasury shall furnish to the Secretary of Health and Human Services such information as the Secretary of Health and Human Services deems necessary in order to carry out the amendments made by this Act.

EFFECTIVE DATE

SEC. 4. The amendments made by this Act shall become effective beginning with December 1, 1982.

Chairman JACOBS. Thank you, sir.

Mr. Hacking.

STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY JACK CHRISTY

Mr. HACKING. Thank you, Mr. Chairman.

With the association's statement included for the hearing record, I would like to summarize.

I am representing the AARP, which has well over 13 million members nationwide.

The way we have come to deliver and pay for health care services in this country has obviously created extremely powerful economic incentives to deliver those services in an inefficient and costly manner, and in the most costly institutional settings.

It is no wonder health care costs in general and hospital costs in particular, have been rising at rates far in excess of the general inflation rate since the mid-1960's, when medicare and medicaid were implemented.

Last year, hospitals pushed their costs up by 19 percent, and passed that cost on to the third-party payors both public and private. Yet the inflation rate was only 9 percent last year.

The incentive structure of the health sector of the economy that prompt inefficient and cost-escalating behavior on the part of providers is largely responsible for the 15-percent-per-year average rate of increase in medicare/medicaid program costs.

This upward cost pressure on the medicare program has prompted proposals to slash medicare program benefits for the purpose of holding down total program expenditures.

The House budget resolution calls for $3.2 billion in savings in medicare in fiscal year 1983.

AARP believes that each proposal to help achieve that or any other target figure has to be evaluated in terms of its potential for avoiding mere shifts in costs away from the medicare program, and to program beneficiaries or private pay patients and private third-party payors, restraining the rate of increase in provider costs and charges, holding down the rate of growth in program spending, and promoting less costly alternatives for the delivery of services.

In the light of these criteria, we are strongly opposed to proposals to increase beneficiary cost-sharing, the "working aged" idea, the health insurance tax for Federal employees' proposal, and any other similar proposals that may come up.

The reason for our opposition to proposals like these is that they do not get at the real causes of the problem—the structure of current economic incentives and provider behavior.

For the near term, AARP continues to insist that an across-the-board limit be imposed on the rate of increase in hospital revenue per admission, a limit to which all hospital providers and all payors, both public and private, would be required to conform.

There are a number of ways of getting hospital providers and payors to observe that kind of a limit. Although they are all regulatory, some are direct, some are less direct and some are even indirect. We had some experience with the direct approach during the economic stabilization program in the early 1970's. The Carter administration also opted for a rather direct regulatory approach. A less direct approach could take the form of Federal financial incentives to encourage and/or coerce the States into establishing an effective mandatory prospective budgeting and rate review program for hospitals.

An indirect approach could be devised through those provisions of the Tax Code that govern the way in which hospital providers, private third-party health payors, employers, and employees are treated for tax purposes, but no matter how adherence to an across-the-board limit is to be achieved, such a constraint can only be relied upon to effect savings in the short term or near term. It is essential that while such a constraint is in place, efforts be undertaken to promote competition including product competition and efficiency in the health care marketplace.

In conclusion, I want to reiterate that the only proposals designed to effect savings in medicare spending for fiscal year 1983 that will be aceptable to AARP will be those that impact upon the providers, especially the hospitals, and do so in a way that prevents those same providers from shifting costs to medicare beneficiaries or other private payors.

Thank you.

[The prepared statement follows:]

STATEMENT BY THE AMERICAN ASSOCIATION OF RETIRED PERSONS

I. INTRODUCTION

The American Association of Retired Persons (AARP) appreciates this opportunity to present to the Congress our views on the Medicare Program in fiscal year 1983 and beyond.

Forging the first budget resolution was particularly difficult this year, perhaps because the deep recession, high unemployment and unprecedented federal deficits required all citizens to help resolve our serious economic problems. Consistently through the budget process, AARP has worked with Congress to develop budget policies that address our problems and that are fair. Like many others, however, AARP is concerned that the large cuts in the Medicare Program for fiscal year 1983 go far beyond what can be achieved through needed reimbursement reform. Even assuming that the House Budget Resolution's mark of $3.2 billion in Medicare cuts is accepted in Conference, (the Senate Budget Resolution calls for over $4 billion in

Medicare cuts in fiscal year 1983), AARP believes such deep cuts will require the elderly to pay more directly out-of-pocket for health care.

Considering the 27 percent increase in Medicare deductibles and premiums last year, large new increases in the elderly's out-of-pocket costs are unfair. Moreover, it is unrealistic to expect the elderly to absorb more costs without irrevocably damaging their limited budgets.

Our testimony today will focus on proposals for cutting Medicare in fiscal year 1983, and on more long term proposals for controlling hospital costs and other Medicare expenditures.

II. MEDICARE AND THE FISCAL YEAR 1983 BUDGET

The proposals to cut Medicare take a variety of approaches. Some are aimed at providers, some at beneficiaries. Recognizing that all cuts in Medicare—whether "provider" cuts or beneficiary cuts—ultimately affect the elderly, it is still possible, nevertheless, to cut Medicare and not increase the out-of-pocket costs paid directly by the elderly.

In evaluating the options for cutting Medicare in fiscal year 1983, it is not enough to analyze options on the basis of program savings alone. Medicare paid approximately 33 percent of all expenditures in community hospitals in 1981. As a result, Medicare influences many facets of the health care sector and vice versa. Proposals to cut it, therefore, must be considered against a broader range of system objectives and criteria. Given the current state of the economy, the health care system and the resources of older Americans, the following criteria are useful in analyzing the various options to cut Medicare.

(1) The proposal must contribute to restraining the escalating rise in health care costs. Hospital costs, which make up approximately 74 percent of Medicare expenditures increased by 19 percent in 1981. Uncontrollable hospital costs are largely responsible for the spiralling rise in Medicare expenditures which, in turn, are a major source of pressure to cut the Medicare program. Unless hospital costs are restrained, there will be a continuous effort to slash the Medicare program.

(2) The proposal should contribute to developing appropriate, less expensive means of delivering quality care. This nation's health care system is based on the most expensive care possible, acute care delivered in institutional settings. Since the federal government is a major purchaser of health care services, it must use its market power to help steer our health care system in the direction of less expensive services delivery alternatives.

(3) Proposals must not shift costs to Medicare beneficiaries. Proposals that simply shift program costs to beneficiaries are, in essence, premised on the notion that the elderly should pay more for health care. Some even believe that just having a Medicare program makes the elderly less cost conscious and, thus abusive of the system. But just the opposite is true. The elderly are very cost conscious because rising health care costs are pushing the total cost of health care beyond the growth in their income. Considering health care needs not covered by Medicare, yet important to the elderly—eyeglasses, outpatient prescriptions, dental care, etc.—and deductibles, coinsurance and premiuum payments required by Medicare, direct expenditures for health care services exceed the portion of the elderly's annual health care bill covered by Medicare. Beneficiary liability for Medicare Part B, physician services alone, is approximately 69 percent of total physician charges due when deductibles, coinsurance and unassigned claims are included. Furthermore, the steady erosion in the number of physicians willing to accept assignment (i.e., accept Medicare reimbusement as payment in full) portends even more increases in beneficiaries out-of-pocket costs for health care services.

Evaluating the smorgasboard of options to cut Medicare against this broader range of criteria reveals that it is very difficult to achieve Medicare savings even close to the $3.2 billion amount called for in the House of Representatives' First Budget Resolution for fiscal year 1983. Thus, to achieve Medicare cuts in that magnitude will require implementing proposals that increase the elderly's direct out-of-pocket costs for Medicare coverage.

There are several proposals to cut federal Medicare expenditures by shifting the costs to program beneficiaries. Last year's cuts increased Medicare deductibles and premiums by 27 percent in order to reach $1.1 billion in Medicare savings. Increases in beneficiaries direct out-of-pocket costs for Medicare have a devastating impact on the elderly's budgets because they in turn cause increases in Medigap insurance premiums. Among the proposals that would increase beneficiaries out-of-pocket costs, the elderly are particularly worried about a new Part A copayment of 10 percent of the Part A deductible in 1983 ($30), for the second through 31st day of hospitalization. Under such a proposal, Medicare beneficiaries' direct out-of-pocket costs could increase as much as 200 percent. Moreover, the $1200 in potential cost shifting represents about 15 percent of the elderly's average per capita income. It must be recognized that enactment of this proposal could thrust millions into poverty and seriously erode the health of those unable to pay the shifted cost burden.

Another proposal of particular concern to the elderly is the so-called working aged proposal by which employers are required to pay health insurance coverage for older workers. This proposal is intended to make employers' health insurance plans the first source of payment for older workers health insurance claims. The effect of it is likely to be a significant reduction in the employment of older workers.

Medicare currently provides primary health insurance coverage by paying all covered expenses for eligible beneficiaries, even if the beneficiary is working and covered by a private health insurance plan. Medicare is the first payor and the private plan supplements Medicare. Under this proposal, however, the employer's health plan becomes the first payor.

Making the employer's health insurance plan the primary source of coverage will force up the cost of employing older workers because the employer's health insurance carrier, faced with primary responsibility for covering health claims heretofore covered by Medicare, will insist on being compensated for the additional risk of exposure. In large firms, such costs could be spread among many workers and thereby moderate the impact of the increase somewhat. But, for the most part, working older persons do not work for large companies or in industries or occupations that are well organized. Hence, the burden of the increased cost of employing them will fall directly on the worker or the employer. In either case, the employability of older workers will be made more difficult.

Moreover, despite the Age Discrimination in Employment Act's provision allowing employers to provide reduced health insurance coverage for older workers (so long as the employer spends the same amount on premiums for older workers as younger workers) this proposal would force employers to provide health insurance benefits for older workers that are equal to the insurance provided younger ones.

The adverse impact of this proposal on the employment of older workers is totally contrary to efforts encouraging older workers to remain in the work force. Furthermore, this proposal necessitates a significantly enlarged intermediary staff to accommodate the vastly enlarged administrative burden of determining which claims or parts of claims are to be paid by the various employer plans in the region and which are to be paid by Medicare.

Finally, the optimistically large savings (over $600 million in fiscal year 1983 alone) projected for this proposal does not include any off-set for income tax and payroll tax revenue expected to be lost to the federal government as a result of declining employment. Only through increased employment opportunities can older workers be expected to maintain financial independence and, therefore, less dependence on government income support programs.

III. LONGER TERM BUDGET ALTERNATIVES THAT ALLEVIATE THE PRESSURE TO CUT MEDICARE BY ADDRESSING THE UNDERLYING CAUSE OF HEALTH CARE INFLATION

Our Association believes that changes in the Medicare program cannot be predicated solely upon reducing the looming deficits in the federal budget. Considering the deficits, we recognize the intense pressure to slash Medicare costs, indeed the pressure to slash the entire domestic program budget, is caused, in part, by the huge deficits projected for this, and the next several fiscal years. The economic recovery envisioned by the 1981 Economic Recovery Tax Act is sputtering and will likely falter because of the overly generous provisions of that Act. The federal government cannot relinquish huge sums of revenue over the next several years, significantly increase spending for defense, and expect the budget to come into balance. Something has got to give. Our Association strongly urges the Congress to modify or repeal provisions of the Economic Recovery Tax Act with a view towards increasing revenues.

A. *The regulatory approach.*—AARP has long urged the Congress to place federal limits on increases in hospital revenues. Such an across-the-board approach would not single out Medicare or Medicaid beneficiaries for special restrictions. Time and again, experience has demonstrated that Medicare-Medicaid specific approaches to hospital cost containment merely leads to cost shifting and thus, no reduction in the rate of increase in total hospital costs.

Unfortunately, Congress has rejected the imposition of uniform, across-the-board limitations on increasing hospital costs. Alternatively, AARP recommends that Congress actively encourage the states to adopt mandatory hospital rate review programs. Such programs have been successful in the six states that have them because they reduce both public and private sector outlays for hospital care. Had all states, for example, held hospital cost increases to the same rate as the six states with mandatory programs, the federal treasury would have saved $12 billion in 1980.

In addition, we urge Congress to direct the Federal government to share a larger portion (perhaps one-third) of the savings in Medicare and Medicaid costs that are achieved through rate review programs in the States. Providing financial incentives for states to initiate effective hospital rate review programs could produce substantial savings to both government and private purchasers of hospital care services.

B. *The competitive approach.*—The essence of the competition theory in the health care sector is simply to change the incentives built into the current health care delivery system. While the Association supports many of the changes advocated by competition theorist, we recognize that the market for health care services is not perfect. The competition model is economically flawed because patients cannot control physicians and hospital costs through their choice of insurers. Nevertheless, the Association believes that elements of the so-called "competition" theory do offer meaningful improvements to the health care delivery system.

Prepayments and prospective reimbursement.—The present practice of reasonable cost reimbursement under Medicare and Medicaid is unsatisfactory to government, hospital, and beneficiaries. For beneficiaries, it drives up program costs, and therefore, has largely precluded any meaningful improvement in the benefit package. Contrary to the assertion that reasonable cost reimbursement neither fully nor adequately compensates hospitals, the fact is that there are almost no incentives within the present system for effectively restraining hospital cost and efficiently managing patient care. The third party, cost plus reimbursement methodology for health care services is the most lucrative imaginable. Competition, if it exist at all between hospitals, is for physicians, special services and equipment that has little if any relationship to prices. Therefore, the Associations support replacing retrospective "reasonable" cost reimbursement with a system of prospectively determined premiums. Negotiated fee schedules, capitation payments and some sort of medical incomes policy is necessary to reverse the current inefficient system of allocating health care resources. In constructing the proper incentives, it is essential to get physicians to surrender some degree of their independence of action and to construct a reimbursement system which gives them a stake in containing health care costs systemwide.

Consumer cost-sharing.—Increased consumer cost-sharing is a basic tenet of competition advocates. In essence, cost-sharing proposals blame the victims by forcing patients to assume the consequences for the decisions of hospitals and physicians. Competition theorists believe that shifting the burden of health care cost more to the patient will eventually reduce cost.

Purchasing health care services, however, is not like purchasing any other commodity because the consumer is seldom involved in deciding on either the form or duration of the services purchased. It is the physician who makes the vast majority of all cost decisions while the third party reimbursement system insulates both the patient and the physician from the cost consequences of the normal supply, demand and cost decisions. Understandably, very few patients, especially older patients, feel qualified to challenge the physicians decision—especially in cases of major, costly illness.

While increased patient cost-sharing will probably reduce the demand for certain services, the Association questions whether the health services foregone would take the form of wasteful, excessive or unnecessary care, or needed preventative type care. It is likely that such cost-sharing would primarily reduce demand for, and access to, outpatient type services. Excessive reliance on copayments to reduce demand is shortsighted to the extent that denying (or deferring) significant portions of the population regular access to health maintenance and preventative care leads to more than compensatory increases in other, more costly types of care (e.g., inpatient hospitalization). Moreover, recent interim findings, in a study by the Rand Corporation, indicate that increased consumer cost sharing has no impact on overall spending for health care. That study readily acknowledges, however, that the elderly were purposefully excluded from the study and, therefore, that the results do not apply to the aged population.

Medicare vouchers.—The Association is somewhat cautious about proposals to institute a medicare voucher system. While we support the underlying capitation concept, we are skeptical that it will be used merely as a means of budgetary relief.

Under the voucher proposal, Medicare beneficiaries would be given a fixed sum or credit with which to purchase their health insurance in the private insurance market. The purpose of the proposal is to restrain the inordinate rate of increase in health care cost by injecting a degree of competition in the choice of a health plan and by making the consumer more sensitive to rising cost by asking them to assume a greater portion of such costs out-of-pocket. As a sweetener, the Medicare voucher proposals usually inlude a catastrophic stop-loss provision that insures beneficiaries against out-of-pocket losses above a threshold amount—say $3000.

Such stop-loss protection means little to Medicare beneficiaries, however, because it applies only to acute care services and ignores the major source of catastrophic health care cost for the aging—long-term (nursing home) care. The lack of a well designed long-term care system encompassing both health and social services in nursing facilities, the community, as well as the home is without question the greatest deficiency in the present health care delivery structure. Plans providing stop-loss or catastrophic protection against inordinate expenditures for Medicare "covered services" only serve to perpetuate this deficiency at the very time that long-term care program costs are being driven up by high rates of inflation, emerging demographic trends and increased utilization.

The key to the success of any voucher proposal is informed consumer choice among competing qualified plans. If consumer "cost-consciousness" or cost-sharing is to be an effective means of developing competition and containing costs, consumers must be active participants in the process. To be active and involved consumers must be informed.

Unfortunately, efforts to inform consumers about health care providers have been blocked by organized medicine's, providers and practitioners, heavy cloak of confidentiality and privacy. As a result, health care consumers lack necessary comparative cost, quality and performance information upon which to base vital health care decisions. It is essential, therefore, that any Medicare voucher plan contain provisions requiring extensive and specific information on the terms and conditions of coverage provided by participating qualified plans.

Perhaps the most difficult element of a Medicare voucher proposal is establishing a realistic voucher amount. The Associations believe that the health status of the individual must be considered in determining a realistic benefit level or voucher amount. Considering individual health status provides participants with the benefit level which is closer to their actual needs and thus, provides a more realistic opportunity to purchase adequate health care coverage.

Considering individual health care status, however, is a two-edged sword. Some may wish to consider it in establishing the amount of the premium. The Association does not support the use of individual health status in setting premiums because those elderly that would have the highest premiums, the elderly with the greatest need for health care services, are the elderly with the least ability to pay. It is unrealistic to expect the poorest most vulnerable elderly to pay the highest health care premiums.

The Association is also concerned about the potential problem of "beneficial selection" by insurance providers which could lead to the most vulnerable elderly obtaining the least amount of coverage. Explicit safeguards against this practice must be a part of any voucher proposal.

Changing the tax treatment of employer contributions to health benefit plans.—Health care competition advocates clearly recognize the role that government plays in fueling the growth in the health care sector by subsidizing the demand side of the equation—largely through tax laws which encourage first dollar broad-based insurance coverage. The amount of revenue loss from these health sector tax expenditures has increased faster than the increase in direct federal outlays in recent years. Consequently, the growth of tax expenditures has focused a growing general awareness on health insurance related tax expenditures as just another form of federal subsidy in the health care sector.

Spiralling health care costs are a major source of the pressure to cut the Medicare and Medicaid programs. Between 1975 and 1979, Medicaid expenditures grew at an average rate of 13 percent per year, Medicare expenditures at 17 percent per year. According to the Department of Treasury's estimate, health insurance related tax expenditures grew at an average annual rate of 19 percent per year during the same period.

It is grossly inequitable to continue cutting direct federal health subsidies, like Medicare and Medicaid, and ignore the fastest growing federal health subsidies—health related tax expenditures. The availability of the tax expenditures to permit employers to deduct the full cost of their health insurance premiums as an ordinary and necessary business expense and that excludes employer paid health insurance premiums from employees taxable income, should be made contingent upon cost restraining reimbursement behavior on the part of the private third party payers. The Association believes that making the employers' and the employees' health insurance tax preference conditional on their group health insurers' adherence to Medicare established hospital reimbursement limits and the availability of a variety of health plans, including HMOs, will create incentives to hold down skyrocketing hospital costs. By conditioning these tax expenditures in such ways, the powerful incentives to develop more comprehensive health insurance coverage (broad, first dollar coverage with low deductible) will be reduced and pressure from employers and employees on carriers and providers will hasten the development of less expensive health care delivery system.

While the current bias toward employees selecting more insurance in place of higher wages may be gradually eliminated, "economically rational decisions" as to the amount and type of insurance employers will finance and employees select may not result. There is little to indicate that employees, given the choice (as in the federal employee health benefit plan), will not select high option, comprehensive coverage even if it means using increasingly scarce after tax dollars. It seems workers, like their retired counterparts, desire protection before they become impoverished by catastrophic illness and not afterwards. This may, in fact, represent the biggest problem with the consumer choice, competition model. For it to be a viable alternative to a more regulatory intensive approach, a significant shift in national attitudes toward health insurance will be required.

But changing attitudes will take time. Thus, the health care market, such that it is, requires a mix of competitive incentives and regulations, and an adequate transition period to accommodate the new dynamics in the health care industry. At this point, elimination of successful regulatory activities such as local health planning, state hospital rate review programs and professional standards review organizations, without major structural changes in the delivery of services and in providers attitudes, is cost promoting. Such successful regulatory systems must be retained and invigorated to control costs during the transition to a more rational, competitive and cost-conscious system of financing and delivering health care services.

IV. OTHER BUDGET PROPOSALS THAT WILL INFLUENCE MEDICARE OUTLAYS

Our Association believes that this Committee should be aware of other budget proposals that, while not in the Medicare program directly, nevertheless if approved by the Congress will clearly escalate Medicare outlays.

First, the proposed phase-out of federal support for local health planning in fiscal year 1983, portends substantial increases in health care costs. In essence, the Administration is offering health care competition in lieu of regulatory "barriers" in the marketplace. While we believe that incentives can change the health care delivery system in constructive ways, we seriously doubt that "competition" in the health care sector alone can provide the strong constraining mechanisms required to control spiralling health care cost inflation. We question the wisdom of dismantling the only proven, community-based cost-containment program in place, before the efficacy of "competition" to control costs has been demonstrated. AARP views health planning and the certificate of need process as a viable state and local decision-making process with demonstrated success. It remains one of the few tools government and health care consumers have in the battle against rising health care costs.

The chief concern among supporters of health planning as well as those who subscribed to the competition theory, is that in the Administration's haste to eliminate health planning and deregulate the health care marketplace, a void will be created and costs will skyrocket—especially Medicare cost reimbursement for hospital capital expenditures—before an effectively competitive marketplace can be achieved.

Given the current reimbursement system, hospitals in particular have been interested in renovating and expanding their facilities more frequently in recent years. The tendency now is to update or replace plant after approximately fifteen years compared to 20–25 years in earlier periods. These pressures are likely to accelerate in the absence of community wide planning and (certificate-of-need) reviews. The accelerated depreciation allowances for capital spending, approved last session, are likely to compound this problem in the absence of local spending review requirements. Such tax changes would allow hospitals to achieve faster write-offs under a less regulated environment without regard to need. Estimates are that over the next four years there will be a 50 percent increase in capital construction ($10 billion more) if the phase-out of local planning is approved.

The direct cost to the Medicare program will be significant. An American Health Planning Association (AHPA) survey of hospital bed expansion projects (1980), projects a minimum of 3,000 additional beds per year and a maximum of 16,000 beds per year will be added to present hospital capacity if health planning is eliminated. In beds alone, this will cost the federal government $127 million a year (based on an intermediate estimate, assuming a 74 percent occupancy rate), a majority of which would come out of the Medicare trust fund. Total federal costs could go as high as $256 million per year. Again, this is for additional hospital beds only. It does not include estimates for additional renovation, replacements, equipment, nursing homes and other elements of the certificate-of-need process. When these additional elements are included, the cost to the Medicare program, the U.S. Treasury, and the public will obviously be even greater.

Unfortunately, the health care industry's Voluntary Effort (VE) to contain health care costs has not even achieved its own very modest goals. To eliminate federal support for health planning just a few years after much of the machinery for the process is finally in place, epitomizes waste in government spending. The Association urges the Congress to maintain a viable local health planning presence and capability that will help reduce Medicare outlays in fiscal year 1983 and beyond.

Finally, the Association urges the Congress to provide eldely Medicare beneficiaries equal access to Health Maintenance Organizations (HMO) through changes in the way Medicare reimburses for services. This would result in real, long-term savings to the Medicare program. As individuals, the elderly for the most part cannot enroll in HMOs. Changing reimbursement from a cost plus to a prospective, prepayment basis for Medicare beneficiaries, with required open enrollment periods, would act as a powerful incentive for the development of the HMO option for all segments of the population. Clearly, retrospective, cost based rembursement is not financially attractive or viable for all but the largest and richest HMOs. Without making these reimbursement changes, the elderly will, for the most part, continue to be denied access to HMOs and Medicare outlays will continue to escalate at unnecessarily high rates.

CONCLUSION

The American Association of Retired Persons believe that Medicare savings in the amount of $3.2 billion for fiscal year 1983 will require increases in the elderly's out-of-pocket costs for Medicare coverage. In light of last year's 27 percent increase in direct out-of-pocket costs for Medicare, further such increases are unfair. Moreover, the elderly simply cannot afford it.

AARP urges the Congress to seriously consider health sector tax expenditures as a mechanism for controlling the rate of escalation in hospital costs and for providing incentives for more prudent purchases of health care coverage.

Chairman JACOBS. Thank you.

Mr. Hutton.

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. The National Council of Senior Citizens believes that, in the long term, the solution to medicare's rising costs will be embodied in a national health plan which will provide all Americans with access to affordable comprehensive health care services. While that is not just the only burden in my testimony, I would like to suggest, Mr. Chairman, that you take the entire statement for the record which I have previously submitted.

And also a statement by President Jacob Clayman of the National Council of Senior Citizens,[1] which was made on March 2, 1982, before this committee, on the subject of medicare cuts, which, in greater detail, goes into the things which we need today. Third, I have submitted an analysis of the expected impact of the cuts as prepared by the research department of the National Council of Senior Citizens.

Chairman JACOBS. Without objection.

[The analysis follows:]

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[1] See Hearing before the Subcommittee on Health, Committee on Ways and Means, "Administration's Proposed Budget Cuts Affecting the Medicare Program," Mar. 2, 1982, Serial 97-53.

FISCAL YEAR 1983 FEDERAL BUDGET

PROPOSED MEDICARE CHANGES

To achieve Medicare budget cuts as deep as $4.1 billion (Senate) or $3.2 billion, the following changes in reimbursement, cost sharing, or eligibility levels may be implemented.

SUBJECT	PRESENT POLICY	PROPOSED POLICY	1983 BUDGET REDUCTIONS (in millions)	EXPECTED IMPACT
Legislative				
Part A Co-payment	First day in hospital paid by beneficiary; full reimbursement for second through 60th day with co-payments thereafter.	Keep deductible and impose an additional patient co-payment on days now fully reimbursed.	$2,100	-severe financial hardship on the beneficiary -will discourage beneficiaries from receiving timely medical treatment -penalty imposed on the elderly population for the lack of cost containment in the health care system.
Eligibility Date	First day of the month in which beneficiary's 65th birthday occurs.	First day of first full month following beneficiary's 65th birthday.	$145	-increased discrimination against older workers -shift of cost to private insurers and employers -increase of financial burden on unemployed or uninsured.
Medicare Part B Deductible & Premium	Deductible of $75 per year (increased 25% from $60 as of 1-1-82) and rate of annual increase in premium level limited to previous year's COLA.	Index the Part B deductible and hold the Part B premium to a constant percentage of program costs.	$305	-increased out-of-pocket cost to beneficiary through increased rates of deductible and premium-growth -potential decreased health status of beneficiary and increased expenditures of Medicare Program if beneficiaries deterred from seeking timely services due to cost.
Insurance for Working Aged	Medicare is primary payer; private insurance is secondary.	Employer required to offer same insurance benefits to employees aged 65 to 69 as to workers under aged 65. Medicare will be secondary payer.	$610	-will encourage discrimination against the older worker -cost-shifting to private employers, insurers, and employees -higher out-of-pocket costs to elderly and higher premiums for all workers -disincentive to keeping seniors in the work force.
Home Health Care	No co-insurance; no limit on number of visits.	20 percent co-payment starting with 20th visit.	$100	-discourage home care and encourage covered institutional care, at greater expense to the Medicare program -absolute reduction in benefits with bias toward higher income elderly -increased out-of-pocket costs of beneficiary

Sources: House and Senate Budget Committee Staff Material
FY 1983 Budget Request of President Reagan

Prepared by: National Council of Senior Citizens

SUBJECT	PRESENT POLICY	PROPOSED POLICY	1983 BUDGET REDUCTIONS (in millions)	EXPECTED IMPACT
Hospital Reimbursement	100% of reasonable costs.	Extend 223 routine cost limits to ancillary services (lab, x-ray, etc.) and limit the annual increase in in-patient revenues per admission to 112 percent.	$800	-reduction of hospital revenues creating strong incentives to turn away Medicare beneficiaries. -shifting costs to other insurers or patients to recoup lost revenue -unacceptable expenditure reductions, e.g., personnel or wage cuts -explicit or implicit refusal by some hospitals to accept Medicare reimbursement leading to greater burden on public hospitals/facilities to take on a disproportionate share of Medicare population -financial failure of institutions such as public hospitals, teaching hospitals, and/or those with high Medicare populations -failure to check inflation because current perverse economic incentives will remain.
Radiologist and Pathologist Reimbursement	100% of reasonable charges.	80% of reasonable charges.	$160	-absolute loss of benefit with increased cost to patient -physician refusal to accept assignment.
Limitation on Annual Increases in Physician Fee Screen, the basis for Medicare B reimbursement	8% per year	5% per year	$ 35	-increased number of physicians who refuse to accept assignment because reimbursement levels too low and out of date -reimbursement loss to beneficiary -increased beneficiary out-of-pocket expenditures.
Update of Physician Fee Screen	July	October	$210	-increased number of physicians who refuse to accept assignment because reimbursement levels too low and out of date -reimbursement loss to beneficiary -increased beneficiary out-of-pocket expenditures.
Regulatory				
Utilization Review (UR) the review of medical care qualify and appropriateness of service use and reduce waste	Performed by providers and physician sponsored PSROs (Professional Standards Review Organization).	Eliminate PSRO's. Perform UR by Medicare intermediaries and contractors with federally established objectives.	$413	-waste of current PSRO and UR mechanisms now in place to perform same function -weaker system resulting in unnecessary service use and increased cost.
Private Rooms	Medicare reimbursement for semi-private rooms inadvertently subsidizes private rooms.	Elimination of subsidy.	$ 54	-some of the same impacts as expected under "Hospital Reimbursement."

SUBJECT	PRESENT POLICY	PROPOSED POLICY	1983 BUDGET REDUCTIONS (in millions)	EXPECTED IMPACT
Charge Limits for SNFs and HHAs	Lower charge limits for free-standing than hospital-based facilities.	Uniform charge limits for hospital-based and free-standing facilities.	$ 18	-if reimbursement rates perceived as too low, could result in increased cost to Medicare patient or passing of costs to other patients to subsidize the Medicare services.
Renal Dialysis Payment Rate	Higher rates for hospital-based than free-standing	Composite, prospective rate for both facilities.	$130	-if reimbursement rates perceived as too low, could result in increased cost to Medicare patient or passing of costs to other patients to subsidize the Medicare services.
Physicians Providing Services in Hospital Outpatient Departments	Reimbursed 80% of reasonable charge, the same rate as physicians with private offices.	Reimbursement levels to be reduced to allow for the fact that payment to the hospital and the doctor includes the same overhead factor.	$160	-absolute loss of benefit to patient since MD likely to pass cost on to patient even under circumstances where reimbursement change justified.
Out-patient Physical Therapy Under Part B, and Other Rehabilitative Services	Limit of $500 for service rendered by independently practicing therapists; reimbursement allowed for services rendered in free-standing rehabilitation facilities. (Became effective in 1980.)	Reduce payment limit to $100, and disallow out-patient rehabilitation facility reimbursement.	$ 4	-absolute loss of benefit -$100 limit makes adequate therapy impossible and limits access to service in rural or low population areas -possible increased cost to Medicare if covered, institutionally-based services used.

Mr. HUTTON. Under such time as there is a national comprehensive health care plan for all Americans, we need a positive, constructive and fair program which will save health care dollars without punishing those who need care, and such a plan, we believe, has to have an across-the-board cost containment program applied toward all providers of health services and including all insurors.

It has a major role for the States in maintaining cost and quality control, and the reform of reimbursement methods toward a system of prospective prenegotiated budgeting for all inpatient and outpatient, institutional and ancillary services, and finally maintenance of at least the current benefit in eligibility at levels under medicare.

We believe that these components are embodied in the health care cost containment plan developed by the Health Security Action Council, which was drafted by an advisory group of professional and technical experts, and I believe that that plan will be submitted in later testimony today.

It is not only the plan currently being discussed as a solution to our health care financing and delivery problems, but we believe it is the only comprehensive plan that we consider to be fair to all parties, and to have the potential for successfully achieving the goals of budgetary savings and preservation of benefits.

We believe that there are many proposals which will actually hurt the older people, budget cuts which call for increased cost-sharing and reduce provider reimbursement, will force the elderly to pay more for the same inefficient health care system which now inadequately meets their total health care needs. Plans which would encourage private market competition, and/or medicare vouchers, Mr. Chairman, could lead to higher out-of-pocket costs for the elderly, adverse risk selection, a dual system of unequal care.

There are a lot of horrors in the so-called suggestions, but we do think that most of the potential salvation lies in a very solid across-the-board, cost-containment plan.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, Members of the Subcommittee, I am William R. Hutton, Executive Director of the National Council of Senior Citizens. Representing over four million elderly persons throughout the country, the National Council of Senior Citizens is a non-profit, non-partisan membership organization with over 4,000 clubs and state and area councils in all 50 states.

I appreciate the opportunity to appear before you today to express my organization's views on the devastating Medicare program spending cuts approved by the House ($3.2 billion) and Senate ($4.1 billion) first budget resolutions for fiscal year 1983, and to discuss what alternatives we believe should be pursued instead.

Before I discuss these points, I would like to underscore two of the elderly's essential needs which must not be neglected in the search for budgetary savings of any kind. One is that their health insurance protection be adequate, efficient, and effective. The other is that their Representatives in Congress, recognizing the vital link between the Medicare program and the elderly's health and financial security, act responsibly to preserve Medicare benefits and strengthen the program even as budgetary savings are being achieved.

I emphasize this point because the National Council of Senior Citizens believes that the Administration and Congressional proponents of the first budget resolutions recently passed by the House and the Senate are neglecting to fulfill these needs. They apparently have forgotten, or have disregarded, what Medicare really is, and must continue to be, for 26 million elderly people. These proponents seem to focus only on how much the program costs.

The advocates of such deep spending cuts should examine how Medicare, in spite of its shortcomings, has enabled millions of elderly to receive health services, and perhaps even improve their health status, without financial ruin. These advocates should focus their "savings" strategies on the real causes of high program costs, the uncontrolled inflation in hospital care and medical services and the perverse incentives of the reimbursement system which drive this inflation. They should endeavor to reduce health care costs for all people. Instead they attack the Medicare program time and time again.

Mr. Chairman, on March 2, 1982, shortly after President Reagan proposed a $2.5 billion Medicare cut for fiscal year 1983, National Council of Senior Citizens President Jacob Clayman testified before this committee. His statements and those of most of his fellow-witnesses expressed strong opposition to the proposed cuts. They also expressed dismay at the inappropriateness of the budget proposals as strategies for reducing Medicare expenditure increases. I would like to quote some of Mr. Clayman's remarks:

"We believe that the proposals: will impose unreasonable financial burdens on elderly persons and will threaten their health status; will shift costs to other health care consumers, private insurers, institutions, and state and local governments; are based on misguided and misleading assumptions; offer no improvements in the health care system, but have the potential to exacerbate existing problems in access, cost, and quality."

The only change we can see between March 2 and today is that the budget cuts now proposed for Medicare are deeper and their impact on the elderly will be far more damaging.

For today's hearing record, I would like to submit a copy of Mr. Clayman's March 2, 1982 statement, as well as an analysis prepared by the NCSC staff which identifies the potential impacts of various Medicare budget reducing proposals. I believe that both documents are relevant to today's hearing. In addition, I believe that they clearly demonstrate that the Medicare cuts are so outrageous, so punishing to the elderly, so fraught with misguided assumptions, so clearly the wrong solutions to problems, and so likely to create even greater problems, that they should be disregarded.

We do not deny that savings in Medicare are desirable. However, they should not be attempted for short-term, ill-targetted budgetary goals. We will unquestionably oppose any proposals which do not achieve savings as a result of Medicare program improvements and/or health industry-wide reform which, at minimum, maintain protection of all beneficiaries, refrain from imposing undue costs on any one group of consumers, providers, or insurers, and which attack the real causes of medical inflation.

Are such budgetary savings possible? We believe they are. Constructive approaches to many of the problems we are discussing here today are well-known and well-documented. As a matter of fact, they have been discussed many times before in hearings such as this one. However, there has been unreasonable and unnecessary opposition to these approaches.

To not aggressively pursue legislation to implement these options now will be as devastating to the elderly as it would be to implement every one of the recommendations made by the Senate's $18 billion Medicare cut proposal and the House's $11.5 billion cut. You see, as long as the Congress evades the real health care expenditure problems of this nation and turns its back on every citizen who needs health care service, regardless of their age or their need, the cost of health care will continue to increase. And in the meantime, the elderly, the sick, and the disabled will be exposed to those individuals in the Administration and the Congress who will continue to blame them for the federal government's increasing health care expenditures.

If Congress fails to pursue constructive alternatives, these short-sighted decisionmakers will continue to penalize the elderly and others through budget cutting rather than taking the responsibility to attack the causes of the growing national health expenditure problem of which Medicare is only a part. The elderly will suffer and the health system problems will continue to grow.

Never has the need for appropriate health care reform been as great as it is today. If the Congress does not implement at least the start of a program before fiscal year 1983, then we will be back again next year and the year after that saying the same thing: "The budget cuts are wrong," and all Americans will continue to pay too much for health care. The state of the economy will continue to reflect the unnecessarily large amounts of private and public resources spent on health care. And deterioration will threaten the nation's health status, imposing unequal impacts on the poor and elderly at the highest risk.

Mr. Chairman, I believe that we should not be asking where to cut Medicare to achieve program savings. Instead, we should be asking entirely different questions in order to arrive at solutions to the problems before us:

Is the federal government the only entity feeling the impact of rising health care costs?

Does medical inflation not affect state and local governments? Consumer prices? People of all ages? Workers who must support families? Employers who must cope with ever-increasing costs? Elderly who find their limited incomes eroded in spite of Medicare?

Medical costs indeed affect all of these groups. However, squeezing Medicare will only shift the problems to others while hurting the elderly. In addition, medical inflation will not be curbed and may even be encouraged since costs in other parts of the health system could rise in response to the government's retraction. The responsible alternative then is to apply industrywide reform which will benefit all purchasers and users of health care, including the Medicare program and its beneficiaries.

The National Council of Senior Citizens believes that in the long term, the solution to Medicare's rising costs will be embodied in a national health plan which would provide all Americans with access to affordable, appropriate, and comprehensive health care services. Until such a plan can be enacted, we need a positive, constructive, and fair program which will save health care dollars without punishing those who need care.

Such a plan must include these essential components:

(1) an across-the-board cost containment program applied toward all providers of health services and including all insurors;

(2) a major role for the states in maintaining cost and quality control;

(3) the reform of reimbursement methods toward a system of prospective, pre-negotiated budgeting for all inpatient and out-patient institutional, professional, and ancillary services; (provisions would be made to allow for changes due to such factors demographic shifts, inflation, population health status, etc.);

(4) maintenance of at least the current benefit and eligibility levels under Medicare, with incentives to develop and expand pre-paid health plans and appropriate lower cost alternatives to institutional, acute and long-term care.

These components are embodied in the Health Care Cost Containment plan, developed by the Health Security Action Council, which was drafted by an advisory group of professional and technical experts. It is not the only plan currently being discussed as a solution to our health care financing and delivery problems. However, it is the only comprehensive plan that we consider to be fair to all parties and to have the potential for successfully achieving the goals of budgetary savings and preservation or enhancement of benefits.

We believe that there are many proposals targetted specifically toward Medicare, or which include medicare as a component, which will render the elderly worse off than they are in today's highly inflated medical economy. For example:

Budget cuts which call for increased cost sharing and reduced provider reimbursement will force the elderly to pay more for the same inefficient health care system which now inadequately meets their total health care needs.

Plans which would encourage private market competition and/or Medicare vouchers could lead to higher out-of-pocket costs for the elderly, adverse risk selection, a dual system of unequal care, increased private sector costs, reduced benefit levels. These plans are not proper solutions to problems of access to services or quality or appropriateness of care. These plans also aim at the wrong targets. It is not the patient who controls the use of health services but the physician.

Proposals which would index beneficiary cost-sharing levels would legitimize the "means testing" of a program that has a significant social insurance component and would endorse treatment of beneficiaries. Further, these proposals would not control health care inflation or encourage industry cost savings.

Recommendations which would restrict Medicare reimbursements but would neither prohibit the billing of Medicare beneficiaries for excess costs nor the shifting of costs to other insurers or private payors would impose excessive financial burdens on the elderly and threaten their health status. Such recommendations would not control health care inflation or encourage industry cost savings.

The National Council of Senior Citizens does not advocate that major reforms be applied to Medicare in isolation because total health system reform is required, and because the potential for cost shifting and continuing inflationary pressures will not be eliminated. However, before major reform can be implemented, savings could be generated by certain Medicare targetted changes. These include changing the reimbursement of health maintenance organization to a prospective system to encourage elderly enrollment and program savings. Another plan would be to implement a hospital prospective reimbursement system under Medicare to be followed by implementation of such a system for all providers and insured of all ages. A third plan which would impact other insurors as well would be to encourage state cost control.

The critical element in any equitable and efficient plan is to balance the health care needs of the elderly and all other citizens with the need to control national health care spending. To assure that this balance is maintained is a vital role of the federal government. We believe that if this subcommittee reports out recommendations for legislation that include some or all of the above proposals, the levels of savings to be called for by the upcoming conference report on the first budget resolution can be achieved. In doing so, this subcommittee will be recommending equitable and efficient Medicare savings strategies.

If the Congress fails to maintain this balance, it will fail the American people by endorsing the continuation of medical inflation and the unequal treatment of people who need health care services. The greatest burden will fall on citizens whose health care needs are the greatest and whose financial resources are the most limited—the 26 million elderly people and the three million disabled persons for whom the Medicare program is vital.

Chairman JACOBS. Thank you, sir.

Mr. Sinn, as I understand, you propose a means test for Medicare, would that be a fair statement?

Mr. SINN. Yes.

Chairman JACOBS. How would you determine the means of a person, simply by a Federal income tax return or would you go in further and see what the family budget is?

Mr. SINN. I think by Federal income tax return.

Chairman JACOBS. So if the person was in municipals and had $5 million a year in income not taxable, that person would go ahead and receive the medicare full insurance?

Mr. SINN. If was adjusted gross was less than 25,000, yes.

Chairman JACOBS. I am saying it is $5 million and it wouldn't appear on the Federal income tax return.

Mr. SINN. That's right. It would not.

Chairman JACOBS. So if you determined by looking at the income tax return, you would miss that fellow, wouldn't you?

Mr. SINN. Yes, we would.

Chairman JACOBS. Would that be all right?

Mr. SINN. No, it wouldn't be all right, and if there is a better way to handle it, we would be perfectly prepared to consult on that.

Chairman JACOBS. I only suggest the dilemma we may face in determining just who has what. I am not rejecting your thought out of hand, but I would say you might take it over to the drawing board and perhaps study that a little bit and see if you could make proposals on administration of such a means test.

Mr. SINN. It is a dilemma. We wanted to be certain, though, we had a floor that was sufficient, that would prevent anyone from—anyone who needed medicare would be able to get it.

We didn't want to remove that medicare safety net. It is true they may have more income by the means testing, though, we are suggesting.

If there is a better way to do it, we would be glad to undertake it. But the most important thing is that that we miss those that shouldn't be missed, but we don't miss those who must have it.

Chairman JACOBS. I express on behalf of the committee my gratitude for the panel. You might be interested to know, Mr. Hutton, in the race for the quickest presentation, your time is 3:29:46, whereas Mr. Hacking was 3:29:52.

That is the way it falls. We will see what happens. You could still be eligible for the dollar and the half-dollar, depending on how your successors do.

Mr. SINN. Mr. Chairman, I take it I am out of the running for that dollar?

Chairman JACOBS. I am sorry—I really am—about that, in more ways than one.

The next panel consists of the American Federation of Labor-Congress of Industrial Organizations, sometimes called the AFL-CIO, Mr. John McGlotten, department of legislation; and the Health Security Action Council, represented by Mel Glasser, director.

Robert, you may proceed.

STATEMENT OF ROBERT McGLOTTEN, ASSOCIATE DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. MCGLOTTEN. Thank you, Mr. Chairman. I have a very brief statement. I will go through it very quickly. I ask that all of the statement and the attachment be included in the record.

Chairman JACOBS. Without objection.

Mr. MCGLOTTEN. Mr. Chairman, the AFL-CIO appreciates this opportunity to testify.

In recent years, rising health care costs have imposed an extremely heavy financial burden on the Federal Government and all health consumers.

Federal expenditures for health care have doubled in the last 5 years. Insurance premiums and medical fees have skyrocketed, and patients are required to pay a great deal more money out-of-pocket for services that insurance doesn't cover.

Frequently, senior citizens and families of jobless workers go without essential medical treatment and, in some institutions, the quality of care dispensed is directly related to the patient's ability to pay.

The Reagan administration's approach to our current health care crisis has been to attack public health and entitlement programs and paint them as villains undermining our Nation's economy.

Rather than proposing thoughtful strategies to contain costs, it has given Congress a blueprint from which to slash current services and protections.

If the cuts that were recently passed by both Houses of Congress are enacted, all of us will pay dearly for years to come. Hospitals would be encouraged to turn away medicare patients.

Employers would lay off older workers, rather than pay more for health insurance, and national immunization programs and health services for mothers and children would be drastically cut back.

All of these punitive proposals would hurt health consumers, while allowing doctor fees and hospital charges to soar to new record levels.

The Reagan administration's only response to the Nation's health care crisis is its so-called competition proposal, which would save money for employers and the Federal Government at the expense of working families and the elderly who would be encouraged to play Russian roulette with their health.

At the same time, however, the administration paved the way for increasing health care costs by taking the unprecedented step of allowing medicare to reimburse antiunion consultants.

Organized labor believes the administration has taken the coward's way out of the health crisis by failing to address the fundamental problems in the health care system.

For it is the providers and suppliers of health care services who decide who needs health care, when they need it, and how much they need. Until serious efforts are taken to change the way providers are reimbursed, there is no relief in sight for the Federal Government or for the financially overburdened consumer.

The ALF-CIO remains convinced that the only way to assure all Americans assess to quality health care they can afford is through the enactment of universal comprehensive national health insurance.

But Americans cannot wait. The alternative that we are proposing to deal with the problems of rising health care costs is needed here and now.

The plan we are suggesting is a viable alternative to the pain and suffering that will exist in our country if the administration's cutbacks in vital health programs are enacted.

The proposal of the Health Security Action Council, which the AFL-CIO has endorsed, would do what needs to be done. It would restructure the current reimbursement system while maintaining the wages, benefits, and contractual rights of employees, so that the real decisionmakers, the providers of health services, would have strong incentives to help bring health care inflation under control.

The AFL-CIO stands ready to work with you, Mr. Chairman, to insure early passage of legislation based on these principles, and we would like to submit additional material for the record.

[The prepared statement and attachments follows:]

STATEMENT OF ROBERT McGLOTTEN, ASSOCIATE DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. Chairman, the AFL-CIO appreciates this opportunity to testify.

In recent years rising health costs have imposed an extremely heavy financial burden on the federal government and all health consumers. Federal expenditures for health care have doubled in the last five years. Insurance premiums and medical fees have skyrocketed, and patients are required to pay a great deal more money out-of-pocket for services that insurance doesn't cover. Frequently, senior citizens and families of jobless workers go without essential medical treatment and, in some institutions, the quality of care dispensed is directly related to the patient's ability to pay.

The Reagan Administration's approach to our current health care crisis has been to attack public health and entitlement programs and paint them as villains undermining our nation's economy. Rather than proposing thoughtful strategies to contain costs, it has given Congress a blueprint from which to slash current services and protections. If the cuts that were recently passed by both Houses of Congress are enacted, all of us will pay dearly for years to come. Hospitals would be encouraged to turn away Medicare patients. Employers would lay off older workers, rather than pay more for health insurance, and national immunization programs and health services for mothers and children would be drastically cut back. All of these punitive proposals would hurt health consumers, while allowing doctor fees and hospital charges to soar to new record levels. The Reagan Administration's only response to the nation's health care crisis is its so-called competition proposal, which would save money for employers and the federal government at the expense of working families and the elderly who would be encouraged to play Russian roulette with their health. At the same time, however, the Administration paved the way for increasing health care costs by taking the unprecedented step of allowing Medicare to reimburse anti-union consultants.

Organized labor believes the Administration has taken the coward's way out of the health crisis by failing to address the fundamental problems in the health care system. For it is the providers and suppliers of health care services who decide who needs health care, when they need it and how much they need. Until serious efforts are taken to change the way providers are reimbursed, there is no relief in sight for the federal government or for the financially overburdened consumer.

The AFL-CIO remains convinced that the only way to assure all Americans access to quality health care they can afford is through the enactment of universal comprehensive national health insurance. But Americans cannot wait. The alternative that we are proposing to deal with the problem of rising health care costs is needed here and now. The plan we are suggesting is a viable alternative to the pain and suffering that will exist in our country if the Administration's cutbacks in vital health programs are enacted.

The proposal of the Health Security Action Council which the AFL-CIO has endorsed would do what needs to be done. It would restructure the current reimbursement system while maintaining the wages, benefits and contractual rights of employees, so that the real decision makers, the providers of health services, would have strong incentives to help bring health care inflation under control. The AFL-CIO stands ready to work with you, Mr. Chairman, to ensure early passage of legislation based on these principles, and we would like to submit additional material for the record.

Statement by AFL-CIO Secretary-Treasurer Thomas R. Donahue,
at a news conference held by the Health Security Action Council
at the National Press Club, Washington, D. C. March 29, 1982
Donahue's statement was read by Bert Seidman,
director of the AFL-CIO Department of Social Security.

The Reagan Administration has taken every opportunity to attack public health care programs and to cast them as villains undermining our country's economy. Now it has stepped up its vendetta by demanding further slashes that will, if Congress yields again to the pressure, mean severe cutbacks in health services for senior citizens, jobless workers and the poor and much higher health insurance premiums and out-of-pocket payments for the rest of us.

The Administration's budget seems to assume that health costs will disappear if the federal government refuses to pay the bill. The cost of health care will not disappear, and neither will the people who desperately need it. In fact, if the Administration's proposals are enacted, all of us will pay dearly, and not only in money. Hospitals would be encouraged to turn away Medicare patients. Employers would lay off older workers, rather than pay more for their health insurance. National immunization programs and health services for mothers and children would be drastically cut back. And at the same time, doctor fees and hospital charges would soar to new record levels.

As a response to the nation's health care crisis the Administration's so-called "competition" proposal is a disaster. It would pretend to control costs by placing a ceiling on employer payments for health insurance, thus forcing cutbacks in health coverage achieved through collective bargaining. A tax gimmick would be used to lure employees to abandon hard-won, high-option health-insurance plans for lower-grade coverage. A variant of the plan involving Medicare vouchers would diminish already inadequate health care protection for millions of elderly and severely disabled persons.

The AFL-CIO and its allies in the Health Security Action Coalition have developed an alternative to the Administration's health budget that would save money without requiring drastic cutbacks in services and without placing an increased burden on taxpayers. Under our proposal the real decision-makers — those who provide and sell health services — would have strong incentives to help bring health care inflation under control. States would have maximum flexibility to devevelop cost-effective reimbursement methods for hospitals and nursing homes. Physician fees would be negotiated in advance, slowing cost increases in private, as well as public, health care. The plan would protect collectively bargained compensation for employees. Health maintenance organizations would be encouraged to develop a better and more humane treatment for the elderly.

The AFL-CIO remains convinced that the only way to assure all Americans access to quality health care they can afford is through the enactment of universal comprehensive national health insurance. But Americans cannot wait. The alternative that we are proposing today to deal with the problem of rising health care costs is needed here and now. It is, in fact, our best judgment that it would save Americans as much as $13 billion in its first year of operation.

In both houses of Congress there are demands for real reform and effective restraint on runaway costs of health care, but there is also an increasing awareness that these goals are not met by putting health care out of reach of those who need it most.

The AFL-CIO is proud to join with the other organizations of this coalition in offering a health care cost-control program that does what has to be done. We will cooperate in every possible way to ensure its early passage.

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HEALTH ★
SECURITY
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COUNCIL

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Douglas A. Fraser, *Chairman*
Melvin A. Glasser, *Director*

THE HEALTH SECURITY ACTION COUNCIL

HEALTH CARE COST CONTAINMENT - A CONSTRUCTIVE APPROACH

Washington, D.C.
April 1, 1982

April 1, 1982

The program herein outlined is a major alternative to the cuts in health programs proposed in the President's Budget.

Labor, business, civic, fraternal, religious, senior citizen and farm organizations, as well as, national and local political leadership agree that skyrocketing health care costs must be brought under control. Last year health costs increased 15.3% over the previous year. This was the highest in our history. This is unacceptable.

This is a national problem. It is not only a problem for the public sector. It is a problem for the private sector as well.

The Administration's approach would again slash Medicare and Medicaid programs, wiping out vital services for millions of children, the disabled and the elderly, while simultaneously shifting the cost of their care to the rest of the economy.

In addition they have been proposing a so-called "competition" proposal. It claims to offer control of health care costs by placing a ceiling on employer and/or employee payments for health insurance. But this plan would not contain costs. It would shift them, through reducing health coverage and transferring charges from insurance to consumers and patients. A tax gimmick would be used to abandon hard-won, high option health insurance plans for lower-grade coverage. A variant of the plan, involving Medicare vouchers, would diminish already inadequate health care protection for millions of elderly and severly disabled persons.

As a national problem, skyrocketing health care costs demand a national solution. Although a comprehensive national health insurance program would be the best solution, it is not a politically viable one for 1982.

Consequently, the next best solution is equitably to control and rationalize health care spending within our present insurance system. Such a program would require equal constraints on the public and private sector, and on the providers and insurers of services.

This solution would deal with all of the principal elements of the health care system. Moreover, it would decentralize many of the critical health cost containment decisions to the state level, with the federal government providing broad guidelines, standards and technical support. If a state is unable to undertake such a program, the federal government could make it available.

In the name of cost containment the Administration is proposing to reduce the federal deficit by shifting billions of dollars from the federal government to patients, doctors, hospitals, private insurance, and already overburdened state and local governments. This approach will not contain costs; it will only cause added suffering and death due to slashed services and entitlements.

There is a better way, a more humane approach, that will protect people and save money. That is why a new comprehensive alternative to the Administration's plan is being proposed.

It would put an immediate brake on health cost escalation, while a new series of state controls, based on prospective budgets and negotiated agreements with providers, insurers and other payors are put in place.

The program will save an estimated five and a half billion dollars in public expenditures in each of the first two years of operation. Of these savings, some one and a half billion dollars would be returned to the states as incentive payments under Medicaid.

The private sector would also benefit. It would be expected to spend annually some seven and a half billions dollars less, without reducing benefits, under this plan, than if the Administration's proposals were adopted.

The new program can effectively begin to produce needed changes, and at the same time protect the consumer. Drafted by an advisory group of professional and technical experts, it contains the following principal features:

1. Comprehensive cost containment across the entire system - public and private, including hospitals, nursing homes and professional providers of health services.

2. State responsibility and flexibility in the cost control process, combined with prospective budgeting and ceilings on hospital and nursing home payments, based on the previous year's expenditures plus increases allowed for the rate of inflation in the economy.

3. In the first 2 years of the plan the state ceiling would be set by the state in accordance with the previously enunciated principle. This would almost cut in half the rate of escalation

of health care costs. Further, it would assure the continuation of the present benefits and entitlements of public programs.

4. Physicians and other professional providers' reimbursements would initially be held to current levels, plus an allowance for inflation in cost of office overhead. Providers could not charge above negotiated reimbursement rates for in-hospital and nursing home services ("assignment").

5. Laboratory and x-ray services would be reimbursed on a negotiated rate schedule worked out among representatives of the public agencies, Medicare intermediaries, providers, insurance companies, consumers, and the laboratories and x-ray organizations.

6. The organization of new health maintenance organizations would be encouraged.

7. A national expert committee would advise the professions and the payors on new procedures and new technology.

8. New programs for more effectively meeting the long term care needs for the elderly and disabled would be encouraged.

Details of the specific proposals are contained in the section which follows.

Hospitals

Since hospitals are the largest single source of personal health expenditures, public and private, control of the increase in their costs would be central to the new comprehensive health cost containment system.

The principal feature of the new program would be a state prospective budgeting system with annual ceilings for both hospitals and nursing homes. Together they constitute almost half of current payments for personal health services. The total budget for state expenditures for hospitals, public and private, but excluding state mental hospitals, would be based on: a) the last year's total expenditures; or b) a typical year in the last three years; or c) the average of the previous three years' expenditures. This would be adjusted by the increase in the Consumer Price Index in the past year.

The percentage increase allowed would be uniform for both public and private sector payment of costs and/or reimbursement. The Federal and state governments would continue to receive discounts which derive from their positions as the major purchasers of hospital services.

Each of the principal payors for hospital care, including Medicare and Medicaid, would be limited in its payments by its previous proportion of hospital care payments to total state spending for hospital care. Annual adjustment would be made for the number of persons enrolled in the programs, their age and health status. The uninsured and others paying out-of-pocket for hospital care would pay directly to the hospital involved with appropriate credit given in hospital budgets for such payments.

Federal Medicare and Medicaid funds would provide the leverage for the new system in each state. The law would require however that private insurance payments, including Blue Cross, would be mandated for inclusion in each state program.

Medicare would continue as a Federal program with full control on eligibility and benefits, and through intermediaries, would continue to monitor program operations to assure the proper implementation of Federal law and policies.

The key to cost control would be however with the states which are closer to the actual delivery system and in a better position to see that the system is both cost efficient and effective.

The states could, as long as they remained within the predetermined ceilings, use their own methods of determining how to pay hospitals within the system. This could be done in a variety of ways: prospective budgeting by category of hospital (e.g. teaching hospital, small, medium or large community hospital, rural hospital, etc.); formulae to set limits on what could be charged various payors; budget reviews of each hospital; capitation payments for defined populations.

State flexibility in adopting their own budgeting plans would be assured, so long as they were based on prospective budgeting and annual predetermined ceilings.

Representatives of health workers would participate in the state wide reimbursement negotiations on an equal basis with hospitals and nursing home officials and the plan would protect collectively bargained rights and benefits for employees.

A State agency, either responsible to the governor directly, or as a semi-autonomous unit in the State Health Department, would manage the program and be responsible for negotiations with the hospitals and the insurers and would provide for adequate consumer representation.

Each state would be required, within 120 days of passage of federal legislation establishing the program, to file with the Department of Health and Human Services notice of intent to operate the cost containment plan. The state would enact implementing legislation. Its plan would be subject to approval by the Department of Health and Human Services.

There would be a federal appeal mechanism which the state could use in the event of disagreement regarding Federal plan approval. Similarly there would be a state appeal mechanism for hospitals and payors (insurance companies, Blues, HMOs) which may have disagreements with the state administrative agency.

Savings from the negotiated budget would be shared by the hospitals, public and private payors. Consumers would participate in the savings through improved services and lower insurance premium rates made possible by hospital cost savings.

Prospective budgeting is a simpler way of reimbursing hospitals than the currently prevailing cost reimbursement system. Therefore, it should yield considerable savings in lowered administrative & recordkeeping costs. At least part of these savings may be required for added allowances for hospitals which serve disproportionately large numbers of the medically indigent for whom no (or reduced) public payments are available.

In negotiating the annual prospective budget the parties would be expected to take into account the need for reduction in duplicate services and excess plant capacity, as well as appropriate planning for changes in technological and physical resources.

States which participate in the program would have the incentive of an approximately 10% reduction in their contributions of Medicaid funds in the coming year. These reductions would be financed from the reimbursement savings engendered by the operation of the cost containment plan.

Since it would in all likelihood take a year or more to make this health care cost containment program fully operative, hospitals would be required to operate for 24 months under a fixed reimbursement formula, adjusted for inflation, as described earlier. Charges and cost reimbursement per patient and charges per procedure in the first year would be fixed at the mean of similar charges for the hospital in the previous 12 month period, plus the increase in the Consumer Price Index for the same period. A further adjustment in reimbursement would allow for any increases in the wages and benefits of non-supervisory employees during the transition period.

In the second year increases up to two-thirds of the increase in the CPI for the previous year would be permitted.

Hospitals could shorten the period of fixed reimbursement rates to 12 months in any state where the plan could be readied for operation in a period less than 24 months.

Nursing Homes

Nursing homes and intermediate care facilities continue to require major and increasing expenditures from Medicare and Medicaid as well as private sector programs. Despite the fact that some 80% of the beds are operated by private for profit owners, competition has not played a meaningful role in containing increases in costs.

Cost containment is essential, but it must not jeopardize decent staffing and facility standards. Unless adequate standards are maintained, quality of care and competence of staff would be eroded.

Accordingly, the state agency charged with administering the hospital program, along with the Medicare intermediary, would also be required to see that existing Federal and state standards are observed within the same prospective budgeting limits as are required of hospitals.

Provisions which apply to hospitals with regard to negotiation of budgets, appeals, savings from budget, employee protections and the maximum 24 months restriction on price increases would apply to nursing homes and intermediate care facilities.

In negotiating the annual prospective budget the parties would be expected to take into account the need for reduction in duplicate services, excess plant capacity, and appropriate planning for expansion of technological and physical resources.

Physicians and Other Providers

Existing reimbursement methods contribute to inflated health care costs by encouraging procedures and discriminating against services that do not involve technology. They fuel cost increases by reimbursing on the basis of charges that are not the result of negotiation among payors, patients and providers.

Under the Health Care Cost Containment Plan, third party payors, including states, insurance companies and third party intermediaries in behalf of Medicare, organized labor, representatives of the public, and representatives of physicians and other independent health professionals would negotiate annual fee schedules or alternative payment arrangements that would be used for reimbursement.

Initially fee schedules would be set at present levels in each of the three programs in the state (Medicare, Medicaid, private insurance). A single level fee schedule is obviously preferable, but would probably be too costly to the public programs in the initial and transition stages. Hopefully, over time, through joint efforts of the parties involved in the state negotiations, movement would be made toward a single schedule or reimbursement arrangement which would be equitable for providers and payors.

Incentives would be built into the payment structure to encourage primary care, disease prevention, and health promotion, and to give appropriate compensation for treatments which are time and process oriented.

The Health Care Cost Containment Program would mandate "assignment" for in-hospital and nursing home services. Providers could not charge above negotiated reimbursement rates. Professional services delivered in these institutions, as well as their nature and frequency, are sufficiently different from ambulatory services to require both a different payment structure and one that reflects total payment.

Since it would in all likelihood take a year or more to make the health provider cost containment program fully effective, states would be authorized to provide for no increases in rates of reimbursement for health providers for a twenty-four month maximum period, except for an allowance for increased overhead costs reflecting the year's inflation rate. Provision would be made for relaxation of these fixed rates after one year if in any state the system could be placed in operation sooner.

Third party payors and the health professionals should be encouraged to develop capitation and other payment arrangements and to be reimbursed on other than a fee-for-service basis. It would be appropriate and desirable for payors, patients and providers to benefit from these savings.

In arriving at appropriate reimbursement schedules due recognition should be given to the cost experience of the previous three years, to adjustment necessary because of anticipated inflation, changes in demographic characteristics of states and local areas, etc.

Payment mechanisms or fee schedules arrived at through negotiation are not designed to reduce compensation of health professionals, but to begin the process of instituting cost increase restraints.

Existing payment patterns in Medicare and some private insurance programs (particularly indemnity insurance) do not provide for full payment for professional services. Accordingly these underpayments are made up by out of pocket payments by patients. Provisions would be made in state requirements that such out of pocket payments could not be increased to make up for the constraints in reimbursements in professional fees.

Laboratory and X-Ray Services

Each state would appoint a laboratory and x-ray payment committee under the Health Care Cost Containment Agency. It would be composed of representatives of the public agency, Medicare, providers, insurance companies, consumers, and the laboratory and x-ray providers. Fee schedules would be developed annually and payments made on this basis. The Committee would be empowered to review appropriateness and frequency of the procedures and technology used.

Health Maintenance Organizations

Separate contracts would be negotiated with HMOs offering them maximum reimbursement up to prevailing costs in the area adjusted by age and health status. The objective would be to avoid selective enrollment of favorable risks.

Unions, employers and insurers would be encouraged to organize new HMOs. Partial forgiveness, up to a stipulated maximum of first year organizing costs of new non-profit HMOs would be provided through provision for write-off as a business expense, or payment of an extra 5% in premiums in each of the first three years of operation.

New Procedures - New Technology

New procedures and new technology have brought important health benefits to millions of Americans. To reduce future costs by denying the fruits of research to future patients is unconscionable. But the fact is that unless we find ways of assuring that new procedures are paid for only when they are appropriately used and that less efficacious procedures are phased out, we will find ourselves unable to finance desirable advances.

The issue of appropriate use of new procedures can, in part, be addressed through fee schedules and other organized payment arrangements. But the refined information needed must be of the highest quality, and the decisions to be taken require professional concensus and acceptance. The national program will therefore authorize organization of a Professional Advisory Committee on New Procedures and Technology sponsored by the Institute of Medicine of the National Academy of Sciences, or within the Department of Health and Human Services, and supported by existing professional bodies. This committee would be given the responsibility to examine the appropriateness of various interventions and the conditions under which they are needed. The efficacy of alternative theraputic regimens, the standards for availability and utilization of various technologies would be reviewed and commented on. The Committee's reports would be advisory to the health professions, administrators of institutions, payors, and those who negotiate payment schedules and prospective reimbursement.

Long Term Care

Meeting the needs for long term care for significant numbers of people, particularly the elderly, continues to be a vexing, expensive and largely unmet issue in health care and in social services.

There is widespread agreement that present patterns of services are often inappropriate, and unduly costly.

Proposed solutions which do not involve large new expenditures are not readily apparent. There is however considerable agreement on at least two principles: 1) Many more chronically ill and severely disabled could and should be cared for at home if appropriate services could be brought to them. Experienced personnel in institutions should be used for many of these home care services. 2) The chronically ill and severely disabled could and should have available to them a combination of health and social services which the present compartmentalization of public programs makes it difficult, if not impossible, to provide.

Accordingly it is proposed that the health care cost containment plan authorize states desiring to do so, to take up to a stipulated percentage of Title XX funds and a percentage of Medicaid funds, to support demonstration projects designed to maintain the chronically ill and severely disabled outside institutions. Continuity of care should be safeguarded through delivery of many of the services by institutional personnel with appropriate contractual protections. Plans like "social HMOs" or "personal care organizations" would thus be encouraged to develop more progressive and possibly cost effective patterns of long term care. Such demonstration projects are more likely to prove meaningful when developed at the local level by knowle knowledgeable people with understanding and a caring attitude about the problem.

In Conclusion

This Health Care Cost Containment Plan is realistic and achieveable within a reasonably short period of time. It would take courage on the part of the Congress to initiate it, for it represents a fresh approach to dealing with the escalation of costs of health care.

This plan would require formulation in legislation. Preliminary estimates of savings involved, however, are so substantial that full implementation would, in F.Y. 1983, make possible:

1) Savings in Federal budget expenditures for Medicare, Medicaid and other personal health services programs comparable to those proposed by the Administration for F.Y. 1983. These, however, would be achieved without further slashes in eligibility or benefits.

2) Beginning relief to the states of constantly increasing expenditures for Medicaid programs without further reducing eligibility or benefits. Approximately 1.5 billion dollars in relief to the states would be expected in each of the first two years.

3) Some 7.5 billion dollars per year savings in insurance and out of pocket payments in the private sector in each year of this plan as compared with the continuation of the status quo.

4) A return to the states of needed initiative and authority to control health costs in their jurisdictions.

5) A halt to cost shifting from federal programs to the private sector, to states and to patients and adequate protections for health care workers.

6) The initiation of sound long range plans for continuing containment of health care costs in both the public and private sectors.

Statement by the AFL-CIO Executive Council

on

Health Care

February 18, 1982
Bal Harbour, Fla.

Even before the Reagan Administration took office some 40 million Americans lacked public or private health care coverage. In the last year, the number of persons without protection for health care financing has risen significantly.

In 1981, the Administration recommended, and Congress acted, to take away Medicaid benefits from at least a million poor people -- mostly low-paid working mothers and their children. Others still on Medicaid suffer sharp limitations in covered services. Some states, taking their cue from the Administration, have cut back their Medicaid programs even more drastically than the new federal restrictions require.

Millions of additional workers and their families lose health care coverage as they lose their jobs. Still more face the same plight as unemployment continues to rise.

In addition to massive lack of health care coverage, the country faces ever mounting medical costs, which continue to far outpace the overall cost-of-living index. Health care workers are not to blame. Since 1972 real wages have fallen 5 percent for hospital workers and more than 12 percent for nursing home employees.

In the face of large scale deprivation of needed health care and rapidly escalating medical costs, the Administration has done nothing to control medical cost inflation or assure access to care.

The unemployed and poor who have nowhere else to go turn to public and inner-city hospitals. In cities all over the country, these hospitals face bankruptcy and closure as a result of expanded caseloads and depleted financial resources. Reduced funding for community health centers has deprived poor and elderly patients of their only source of care. The health care program for migrant workers and their families has also been gutted.

Public health service hospitals, which in recent years served not just merchant seamen and their families but also many low-income persons, have been closed. The health planning program, which has focused on rationalizing the health care system, is being rapidly phased out. Likewise being dismantled is the National Health Service Corps which gave young physicians a chance to practice in underserved rural and urban areas. Funding for health maintenance organizations (HMOs), which provide prepaid comprehensive services in the most cost-effective manner, has also been withdrawn. The Administration is cutting funds for the Centers for Disease Control, the principal agency for identifying and controlling the spread of infectious diseases.

To the disastrous health care crisis the nation faces, the Reagan Administration offers only one response -- its so-called "competition" proposal. The Administration would use tax gimmicks to put a ceiling on employer payments for health insurance and thus force labor and management to reduce health care coverage achieved through collective bargaining. Tax rebates would be offered to entice employees to choose the lowest cost plans with the worst health care cost protection. HMOs would be especially hard hit since they could not offer their customary comprehensive coverage at the cut-rate premiums the proposal would mandate. A variant of the proposal, using a medical voucher scheme, would sharply restrict Medicare services for the elderly and severely disabled.

While severely restricting health care protection, the "competition" proposals would do nothing to expand the opportunity for affordable health coverage for millions of unprotected Americans. These proposals would leave doctor fees or hospital charges completely uncontrolled. Also untouched is the alarming trend toward unrestrained and often ineffective use of the most costly technological equipment and procedures in medical care. Insurers would "compete" to cover the healthiest and wealthiest through expensive marketing and advertising campaigns. While placing additional cost burdens on patients, the "competition" scheme would place no cost restraints on doctors, hospitals or insurers.

The AFL-CIO will continue to oppose the enactment of "competition" legislation.

The only way to assure all Americans access to quality health care they can afford is through enactment of universal comprehensive national health insurance. Until that long-sought goal is achieved, genuine health care cost control legislation would be highly desirable. Such a program would require negotiated budgets with full worker and patient protections for hospitals and negotiated fair fee schedules for physicians.

We will fight any further cutbacks in Medicare, Medicaid and other programs which provide health care for the poor, the elderly, the disabled and other disadvantaged Americans. We will strive for legislation maintaining health care protection for workers who lose their jobs. We support enactment of H.R. 5199 which would permit states to restore coverage for the working poor and their families who were deprived of Medicaid when they lost their welfare eligibility.

We will not rely on the legislative route alone. We urge AFL-CIO affiliates through collective bargaining to seek to improve the financing, organization and delivery of health services. By using their bargaining powers as purchasers of health care, unions can provide some cost relief without sacrificing care for their members and their communities. Together with employers and other community leaders, unions can help to develop prepaid group practice plans on a local community level.

An important task is to start now to organize local area coalitions involving labor, management, and other concerned groups in the community to take whatever steps may be effective to help restrain health care costs and improve the quality of and expand access to health care. We, therefore, welcome the statement of six national organizations representing providers, insurers, business and organized labor pledging a determined effort to promote the development of such coalitions. While the agenda and composition of each coalition will be determined locally, one effective measure that should be considered is to seek agreement by the parties represented in the coalition to develop mechanisms for negotiation of hospital budgets and physician fees as a way of restraining medical cost escalation.

We urge our affiliates to recommend to their local unions active participation in these groups.

NOTE: Factsheet

FACT SHEET
on
Health Care

Overview

The Reagan Administration's war on the poor, the aged, working people and consumers was largely won in the last conservative Congress. Not satisfied with winning a major battle, the Administration has announced its intention of cutting the federal budget for fiscal year 1983 another $35 billion to come primarily out of health and public welfare programs. A major target will be the entitlement programs of Medicare and Medicaid.

The Omnibus Budget Reconciliation Act of 1981 included the following program reductions:

* **Medicare** -- The annual deductible for medical insurance (Part B of Medicare) was increased from $60 to $75. The hospital deductible (Part A) for the first 60 days in the hospital was raised from $204 to $260. For a hospitalization that lasts more than 60 but not more than 90 days, patients will have to pay $65 a day (up from $51) and for the 60 reserve days, they will have to pay $130 instead of the present $102. After 20 days in an extended care facility, a patient will have to pay $7 more for the 21st through the 100th day. These and other Medicare cuts will total $305 million in 1982, $1.8 billion in 1983 and over $2 billion in 1984 -- all out of the pockets of the elderly and severely disabled.
* **Medicaid** -- The President's proposed ceiling on federal Medicaid expenditures was rejected by Congress, but the Reconciliation Act provides for a reduction in the projected costs of the program of 3 percent, 4 percent and 4.5 percent in the next 3 fiscal years thereby achieving a savings of about $3 billion in FY 1983. These slashes will come out of the pockets of the jobless and the poor. The $3 billion cut in federal matching funds will require the states to take legislative or executive action to restrict eligibility benefits and/or provider

reimbursement. So far, 35 states have acted. For example, 14 states have adopted changes reducing the number of eligibles. Four states no longer cover AFDC-UP (aid to families with an unemployed parent) families.

Restrictions in the new law on eligibility for Aid to Families with Dependent Children (AFDC) based on income will mean thousands of patients will lose their welfare payments and eligibility for Medicaid. Working mothers, in particular, have had to quit working to maintain their AFDC and Medicaid benefits which often amount to more than their earnings.

To add insult to injury, the Reagan Administration has proposed relaxing or repealing rules that govern nursing homes, the rights of patients and the qualitifications of staff including a current requirement that nursing homes must not employ people with communicable diseases. These rules were, at least, some protection for nursing home patients in some of the profiteering private nursing homes.

Block Grants

The Administration's budget proposal provided for the consolidation of 25 health programs into just two block grants to the states with minimal federal oversight. The Administration succeeded in obtaining $1.2 billion in cuts. Vigorous advocacy by health organizations, consumer groups and organized labor and the strong leadership of Congressman Henry Waxman (D-CA) saved some of the categorical programs including childhood immunization, tuberculosis and venereal disease control, family planning, primary care research and development and migrant health centers which continue as federal programs. One new categorical grant program was created: the Adolescent Family Life or, as it came to be known, the "teenage chastity bill." The other 19 health grant programs were combined into four block grants with, at least, some federal strings. They are:

- **Maternal and Child Health Block Grant** which includes the old Title V of the Public Health Service Act, maternal and child health and cripple children's services program, and six other programs, the most important of which are supplementary security income for disabled children, lead-based paint poisoning prevention, adolescent pregnancy and genetic disease programs. Funds for these programs were cut from $456 to $347 million, or 24 percent.
- **Preventive Health and Health Services Block Grant** combining eight programs, the most important being: home health, fluoridation, health education, emergency medical services, hypertension and health incentive grants. These programs were axed from $99 to $82 million, or 17 percent.
- **Alcohol, Drug Abuse and Mental Health Block Grant** which continues the old community mental health centers and alcohol and drug abuse services with a budget reduction of 24 percent.
- **Primary Care Block Grant** continues the community health centers as a separate program and gives the states the option of whether to administer the centers themselves or allow the federal government to continue doing so. The program was cut about 15 percent.

Organization of Health Services

- **Health Maintenance Organizations (HMOs)** -- Grants to start new programs were eliminated. Only $20 million was authorized for guaranteed loans for developing plans. The sum could only support five or six new plans to become operational. About 100 developing plans will either have to close their doors, with a waste of federal dollars, or be taken over by private investors as profit making operations.
- **Health Planning** -- The reconciliation bill authorizes the planning program, but only for one year. The Administration's plan to terminate federal support this

year was not adopted, but funding for planning was substantially reduced to $102 million. The deadline for state compliance for certificate of need (CON) has been extended to October 1, 1982. Federal funds for state CON laws have been terminated.

* **Public Health Service Hospitals** -- The PHS hospital system for merchant seamen in existence for over a century has been phased out.

Drugs

Regulations governing the marketing and sale of prescription drugs have been greatly weakened by the Administration. For example, the regulation requiring patient package inserts containing basic, easy-to-understand information on contraindications and possible adverse side effects from taking prescription drugs has not been implemented. The regulations governing the testing of new drugs for saftey and effectiveness have also been weakened.

Proposed New Cuts by Administration

Yet to be acted upon this year are additional proposals to cut the budget another $43 billion. Among these are:

* **Medicare** -- Requiring employers to continue private health insurance for those who continue to work after age 65. Over 65 workers would lose their Medicare coverage. Requiring federal employees to begin paying the Medicare tax of 1.3 percent. Indexing the Part B Medicare premium to the cost-of-living. Instituting co-payments for home health services of 5 percent for the first 100 visits (about $2.40/visit) and 20 percent thereafter. Home health visits are currently free.
* **Medicaid** -- Charging Medicaid patients for a part of the cost of physician and hospital care in the form of co-payments. Allowing states to require that

families of Medicaid patients in nursing homes pay part of the cost of their stay. Reducing federal payments for optional benefits under Medicaid such as eyeglasses, dental care and physical therapy. Limiting federal reimbursement to the states for administrative costs.

These changes would cut expenditures for Medicare and Medicaid by $4.7 billion in FY 1983. See attached chart.

Both the enacted and proposed budget cuts would be totally unnecessary if a universal and comprehensive national health insurance program were enacted in the United States. For example, Canada spent 6.1 percent of its Gross National Product (GNP) on health care in 1965 before it enacted a comprehensive and universal national health insurance program. In that year, the United States spent less than Canada, or 5.9 percent. After national health insurance was enacted in that country, medical care costs rose less rapidly than in the United States. By 1970, Canada was spending 7.1 percent of their GNP for health while the U.S. was up to 7.5 percent. In 1975, Canada was still spending the same, or 7.1 percent, while the U.S. was spending 8.6 percent of its GNP. Since 1975, health care costs have decreased to 7 percent in Canada and have been maintained at the same percentage through 1980. In the United States, health costs have risen from 8.6 percent in 1975 to 9.4 percent of its GNP in 1980. See attached chart.

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PROPOSED REAGAN CUTS FOR FY 1983

The following summarizes the major cuts in the Administration's FY 1983 health budget. The details and final estimates may differ when actual FY 1983 budget is submitted to the Congress.

-- **Medicaid** -- Federal Medicaid payments to the states would be cut by about $2.2 billion in FY 1983. This cut is on top of the $0.9 billion cut already programmed into FY 1983 by the Reconciliation Act that was enacted just six months ago. These cuts would be shifted to hard pressed state and local governments, and to the aged, blind, and disabled poor and dependent children.

-- **Medicare** -- Medicare would be cut by about $2.5 billion in FY 1983. This cut is in addition to the $1 billion cut already programmed into FY 1983 by last year's Reconciliation Act. These costs would be shifted to the elderly and disabled, to health providers, and to state and local governments.

-- **Family Planning** -- This program was funded for $162 million in FY 1981. Last year, after a vigorous debate about including it in a block grant, the Congress retained it as a categorical program, with funding at a reduced level of about $124 million. This year's budget again proposes to repeal and consolidate the program into an unrelated health services block grant.

-- **Maternal and Child Health, and Special Supplemental Food Program for Women, Infants, and Children** -- The FY 1983 budget proposes to combine these programs into a block grant, and to cut authorized funding by about 22 percent -- $300 million less than the FY 1982 funding level, and nearly $600 million less than required to maintain the programs at the FY 1981 service level. The Administration could be expected to request further cuts during the appropriations process.

-- **Nursing Programs** -- The FY 1983 budget proposes to cut these programs to $12.5 million, compared to the FY 1981 level of $80 million, and FY 1982's reduction to $47.3 million. Student loans would be eliminated. Coupled with last year's changes, that would mean that no financial aid would be available to students attending nursing school, despite the nationwide shortage of nurses.

-- **National Health Services Corps Scholarships** -- The FY 1983 budget proposes to cut this program to $11 million, compared to the FY 1981 level of $63 million, and FY 1982's reduction to $36 million. No new scholarships would be provided, eliminating a future source of physicians for medically underserved communities across the nation.

-- **Centers for Disease Control** -- The FY 1983 budget of less than $300 million makes no effort to rectify the serious cuts in the FY 1982 budget. Those cuts are expected to reduce the effectiveness of a number of CDC's programs, such as immunizations and VD control.

-- **National Institutes of Health** -- NIH funding for FY 1983 would be $3,660 million. This represents less than a 3 percent increase over FY 1982, and constitutes a reduction in the real dollars available to NIH after adjustment for inflation.

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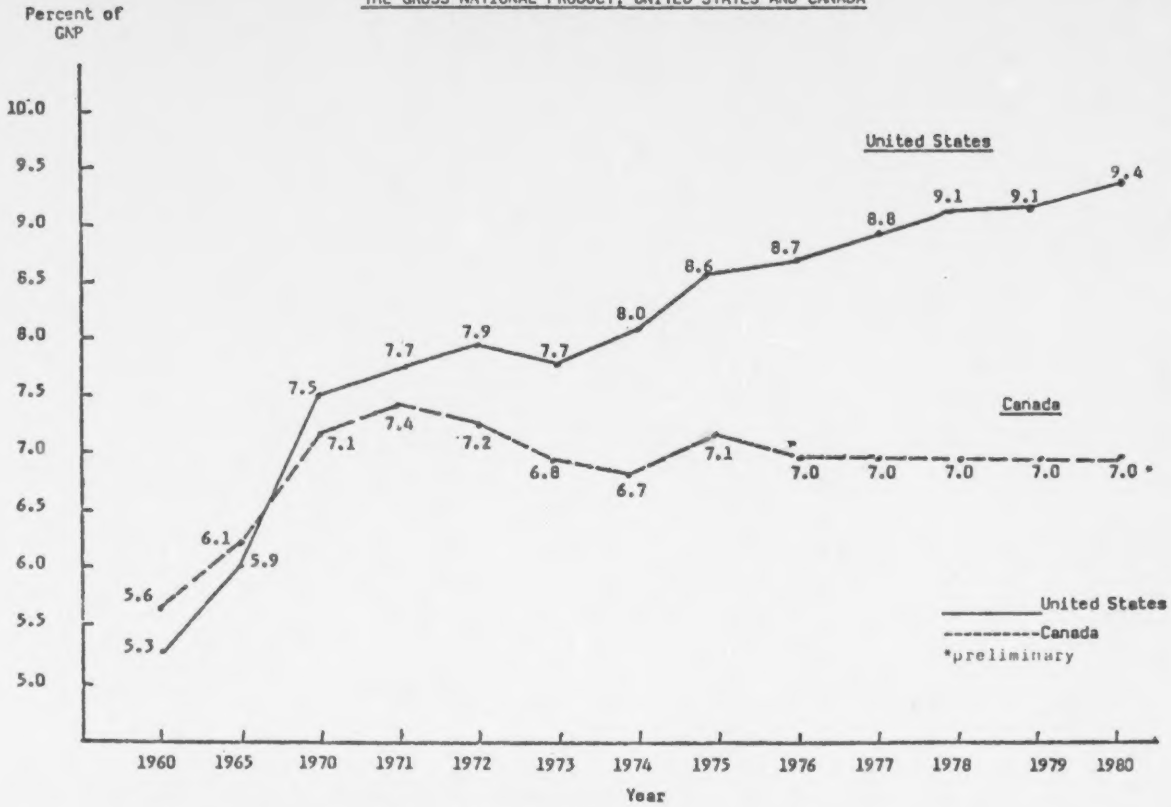
Source: Health Subcommittee, House Energy and Commerce Committee

HEALTH EXPENDITURES AS A PERCENT OF THE GROSS NATIONAL PRODUCT, UNITED STATES AND CANADA



Source: National Health Expenditures in Canada, Health and Welfare Canada
United States: Department of Health and Human Services

Chairman JACOBS. Thank you, Mr. McGlotten. The record should show it is Robert McGlotten, I think I was misinformed by a local newspaper.

Mr. Glasser.

STATEMENT OF MELVIN A. GLASSER, DIRECTOR, HEALTH SECURITY ACTION COUNCIL

Mr. GLASSER. Mr. Chairman, may I express appreciation in behalf of the Committee for National Health Insurance and the Health Security Action Council for this opportunity to make a brief presentation on a constructive alternative method to constrain public and private expenditures for needed health care programs.

We are, as I believe you know, a coalition of 100 prominent Americans, and labor, business, civic, fraternal, religious, farm, and senior citizen organizations. Our chairman is Douglas A. Fraser, president of the UAW. Thomas A. Donahue, of the AFL-CIO, is our secretary-treasurer.

May I first state that we are completely opposed to the huge expenditures cuts in social programs voted in recent weeks by both the House and Senate.

In our view, they constitute cruel and unfair punishment of the needy, the elderly, the sick and the disabled.

When, for example, a medicare beneficiary already is paying 19.1 percent of his income for medical care, the added financial burden imposed on him as a result of the program slashes the new cuts will require, is unusually severe.

The AFL-CIO, a member of our council, is filing a full statement outlining reasons why this committee should reject the proposed health program reductions.

We shall not, therefore, go further into this aspect of the problem.

Since it seems likely that drastic cuts in health programs will be adopted by both Houses of the Congress, we would like to propose a constructive alternative.

This plan was developed by an expert advisory group of our council after many months of study.

In the brief time allotted, I can only touch on the highlights. If the problem commends itself to you, as I believe it will, members of our expert group will be glad to meet with you and your staffs to fill in the details.

I also request permission to file for the record a full statement of the proposal.

Chairman JACOBS. Without objection, it is ordered.

[The information follows:]

H.A.L.T.! (HEALTH ACTION TO LIMIT TAKEAWAYS)

A CONSTRUCTIVE APPROACH TO HEALTH CARE COST CONTAINMENT

H.A.L.T. is a comprehensive plan to contain health care costs while at the same time protecting consumers of care.

It offers an alternate way of achieving savings in public expenditures comparable to those required by the Congress in the Budget Committees Goals for FY 1983.

It makes possible comparable savings for private sector health payors.

Labor, business, civic, fraternal, religious, senior citizen and farm organizations, working together in the Health Security Action Council, are agreed that skyrocketing health care costs must be brought under control.

But they are opposed to measures which would again slash Medicare and Medicaid programs, wiping out vital services for millions of children, the disabled and the elderly, while simultaneously shifting the costs of their care to the patients, the states and the rest of the economy.

There is a better way . . . . . . it is H.A.L.T.

H.A.L.T., developed by an expert advisory group, after months of study, would control and rationalize health care spending within our present insurance system. Although a comprehensive national health insurance program would be the best solution, since it does not appear politically viable at this time, H.A.L.T offers an immediate program of restraining costs *and* protecting consumers.

WHAT H.A.L.T. WOULD DO

1. Make possible savings in Federal budget expenditures for Medicare, Medicaid and other personal health services programs in F.Y. 1983 and in subsequent years comparable to those mandated by the Reconciliation Budget of June, 1983.

These however would be achieved without further slashes in benefits or eligibility.

2. States participating in the plan would receive incentive payments in the form of reductions of approximately 9% in the funds they are required to spend for Medicaid matching.

3. Comparable savings would be made possible for private sector health insurance.

4. New protection would be provided to private health insurance through putting an end to further cost shifting.

5. The states would have substantially increased authority, within Federal guidelines, to control all health care costs within a state.

6. H.A.L.T. would make possible, over the next two years, a system to contain health care costs in an orderly way. The frantic, haphazard annual efforts by the Congress to effect needed savings would largely be avoided. Program planning and rationalization of services would be encouraged and would be related to necessary fiscal constrainst.

7. H.A.L.T. covers the principal elements which affect costs: hospitals, nursing homes, physicians and other professional laboratory and x-ray services, health maintenance organizatons, and new procedures and technology. H.A.L.T. is based on the conviction that effective cost containment cannot be achieved by trying to save money in one sector, like hospitals, or in one program, like Medicare. This approach only results in shifting costs to the other elements or programs.

PROGRAM FEATURES

1. H.A.L.T. would be implemented in two phases: a) An immediate halt to permissable price increases, beginning approximately 100 days after passage of the legislation. b) A two year period for each state to develop the continuing cost containment mechanism and put it into operation.

If a state were unable to develop a plan meeting the criteria in the legislation, the Federal government would be authorized to step in.

2. Hospitals and Nursing Homes—In Phase I these institutions would be required to hold annual budgets and charges to the amounts expended in the previous year, or a model year in one of the past three years, plus the increase in the "Market Basket" index for hospital in-patient operating costs for the previous year.

Nursing Homes—Rates of return on investment for proprietary skilled nursing facilities would, for reimbursement purposes be contained within a ceiling of the average rate of interest of the Federal Hospital Insurance Trust Fund (Present authorized return is 50 percent higher).

In Phase II, after 24 months, a hospital prospective budgeting system would be mandatory on a state by state bases. The state would be required to hold total expenditures for hospitals to the previous year's expenditures within the state, plus the increase in the "Market Basket" index.

The states could, as long as they remained within the predetermined ceilings, use their own methods of determining how to pay hospitals within the system. This could be done in a variety of ways:

Prospective budgeting by category of hospital (e.g. teaching hospital, small, medium or large community hospital, rural hospital, etc.); formulae to set limits on what could be charged various payors; budget reviews of each hospital; capitation payments for defined populations.

3. Physicians and other professional Providers.

Initially in Phase I, fee schedules would be set at present levels in each of the three programs in the state (Medicare, Medicaid and private insurance). The only increases permissable would be a factor for the increase in overhead costs as reflected in the previous year's average increase in the costs of medical office overhead.

In Phase II reimbursement arrangements, including fee schedules, would be based on negotiated agreements by the providers with the state agency. Representatives of Medicare, the prepayment organizations, and consumers would be part of the negotiations.

4. Laboratory and X-Ray Services—In Phase I the principle of present charges plus a factor for the previous year's average increase in overhead costs would be followed.

In Phase II a laboratory and x-ray payment committee under the state agency, and consisting of representatives of the public agency, Medicare, laboratory and x-ray providers, insurance companies and consumers would negotiate annual reimbursement schedules. The Committee would be empowered to review and set standards for appropriateness and frequency of the procedures and technology use.

5. Health Maintenance Organizations—The state agency would negotiate separate contracts with HMO's permitting maximum reimbursement up to average per capita costs in the area, adjusted by age or health status.

Subsidies would be available, within these parameters, to encourage the development of new non-profit HMO's.

6. New Procedures—New Technology—A professional Advisory Committee on New Procedures and Technology would be set up at the national level to advise the professions and the states on the appropriateness of new technology and the effectiveness of alternative therapeutic regimens. This committee could be either in the Department of Health and Human Services or the Institute of Medicine of the National Academy of Science.

7. Long Term Care—States would be authorized to use up to a stipulated percentage of Title XX funds and a percentage of Medicaid funds to support demonstration projects designed to maintain the chronically ill and severely disabled outside institutions, where appropriate.

H.A.L.T. is a realistic and achievable cost containment program which protects beneficiaries and patients. It is based on accepted principles in health care. It calls a halt to takeaways of benefits and shifting of costs from one sector to another.

The principal drawback to H.A.L.T. is that it does not extend eligibility for care to tens of millions of Americans without such needed protection. It also does not provide for new urgently needed life saving benefits, like prescription drugs for the elderly.

H.A.L.T. calls a halt to further takeaways of benefits and cost shifting from one sector to another. It begins to put into place sound long range plans for continuing restraint on health cost increases in both the public and private sectors. It is a consumer oriented plan which is realistic and achieveable. As such it merits support by all Americans. It is a constructive alternative to cost containment efforts which until now have been tried and have failed.

Mr. GLASSER. First, let me hit the highlights.

First. The Health Security Action Plan would make possible savings in Federal budget expenditures for medicare, medicaid, and other personal health services programs in fiscal year 1983 and in subsequent years, comparable to those proposed by the administration.

These, however, would be achieved without further slashes in benefits or eligibility.

Second. States participating in the plan would receive incentive payments in the form of reductions of approximately 10 percent in the funds they are required to spend for medicare matching.

Third. Comparable savings would be made possible for private-sector health insurance.

Fourth. New protection would be provided to private health insurance through putting an end to further cost-shifting.

Fifth. The States would have substantially increased authority, within Federal guidelines, to control all health care costs within a State.

Sixth. The plan would make possible the evolution of a program over the next 2 years which would establish a system through which in an orderly way, health care costs could be contained.

The frantic, haphazard annual efforts by the Congress to effect needed savings would largely be avoided.

Program planning and rationalization of services would be encouraged and would be related to necessary fiscal constraints.

Seventh. The plan provides for comprehensive cost containment for the public and the private sectors. It covers the principal elements which affect costs, hospitals, nursing homes, physicians, and other professional providers, laboratory and X-ray services, health maintenance organizations, and new procedures and technology.

It is based on the conviction that effective cost containment cannot be achieved by trying to save money in one sector, like hospitals, or in one program, like medicare.

This approach only results in shifting costs to the other elements or programs.

Now, the program features, Mr. Chairman.

First, the plan would be implemented in two phases: *(a)* Phase 1 is an immediate halt to permissible price increases beginning approximately 100 days after passage of the legislation; *(b)* phase 2 is a 2-year period for each State to develop the continuing cost-containment mechanism and put it into operation.

Second, hospitals and nursing homes—in phase 1, these institutions would be required to hold annual budgets and charges to the amounts expended in the previous year, or a model year in one of the past 3 years, plus the increases in the BLS cost-of-living index for the previous year.

In phase 2, after 24 months, a prospective budgeting system would be mandatory for hospitals and nursing homes on a State-by-State basis.

The State would be required to hold total expenditures for each of the two programs to the previous year's expenditures within the State, plus the cost-of-living factor.

The States could, as long as they remained within the predetermined ceilings, use their own methods of determining how to pay hospitals within the system.

This could be done in a variety of ways: Prospective budgeting by category of hospital (e.g., teaching hospital, small, medium, or large community hospital, rural hospital, et cetera); formulae to set limits on what could be charged various payors; budget reviews of each hosptial; capitation payments for defined populations.

Third, physicians and other professional providers: Initially in phase 1, fee schedules would be set at present levels in each of the three programs in the State (medicare, medicaid and private insurance). The only increases permissible would be a factor for the increase in overhead costs as reflected in the previous year's increase in the cost-of-living index.

In phase 2, reimbursement arrangements, including fee schedules, would be based on negotiated agreements by the providers with the State agency. Representatives of medicare, the prepayment organizations and consumers would be part of the negotiations.

Fourth, laboratory and X-ray services—in phase 1, the principle of present charges plus a factor for cost-of-living on the overhead costs would be followed.

In phase 2, a laboratory and X-ray payment committee, under the State agency, and consisting of representatives of the public agency, medicare, laboratory and X-ray providers, insurance companies and consumers would negotiate annual reimbursement schedules.

The committee would be empowered to review appropriateness and frequency of the procedures and technology use.

Fifth, health maintenance organizations: The State agency would negotiate separate contracts with HMO's permitting maximum reimbursements up to prevailing costs in the area, or 95 percent of them, adjusted by age or health status.

Subsidies would be available, within these parameters, to encourage the development of new nonprofit HMO's.

Sixth, new procedures—new technology—a professional advisory committee on new procedures and technology would be set up at the national level to advise the professions and the States on the appropriateness of new technology and the effectiveness of alternative therapeutic regimens.

This committee could be either in the Department of Health and Human Services or the Institute of Medicine of the National Academy of Science.

Seventh, long-term care: States would be authorized to use up to a stipulate percentage of title XX funds and a percentage of medicare funds to support demonstration projects designed to maintain the chronically ill and severely disabled outside institutions, where appropriate.

Mr. Chairman, in brief, this is a detailed, realistic, carefully worked-through proposal that could meet the committee's goals of saving costs, but more importantly, can do them in an orderly way without penalyzing the consumers of services.

Thank you.

[The prepared statement follows:]

STATEMENT OF MELVIN A. GLASSER, DIRECTOR, HEALTH SECURITY ACTION COUNCIL

Mr. Chairman, Members of the Committee: May I express appreciation in behalf of the Committee for National Health Insurance and the Health Security Action Council for this opportunity to make a brief presentation on a constructive alternative method to constrain public and private expenditures for needed health care programs.

We are, as I believe you know, a coalition of 100 prominent Americans, and labor, business, civic, fraternal, religious, farm and senior citizen organizations. Our chairman is Douglas A. Fraser, president of the U.A.W. Thomas A. Donahue of the AFL-CIO is our secretary-treasurer.

May I first state that we are completely opposed to the huge expenditure cuts in social programs voted in recent weeks by both the House and the Senate. In our view they constitute cruel and unfair punishment of the needy, the elderly, the sick and the disabled. When for example a Medicare beneficiary already is paying 19.1% of his income for medical care, the added financial burden imposed on him as a result of the program slashes the new cuts will require, is unusually severe.

The AFL-CIO, a member of our Council, is filing a full statement outlining reasons why this Committee should reject the; proposed health program reductions. We shall not therefore go further into this aspect of the problem.

Since it seems likely that drastic cuts in health programs will be adopted by both houses of the Congress we would like to propose a constructive alternative. This plan was developed by an expert advisory group of our Council after many months of study.

In the brief time allotted I can only touch on the highlights. If the program commends itself to you, as I believe it will, members of our expert group will be glad to meet with you and your staffs to fill in the details. I also request permission to file for the record a full statement of the proposal.

HIGHLIGHTS

1. The Health Security Action Plan would make possible savings in Federal budget expenditures for Medicare, Medicaid and other personal health services programs in fiscal year 1983 and in subsequent years comparable to those proposed by the Administration.

These however would be achieved without further slashes in benefits or eligibility.

2. States participating in the plan would receive incentive payments in the form of reductions of approximately 10 percent in the funds they are required to spend for Medicaid matching.

3. Comparable savings would be made possible for private sector health insurance.

4. New protection would be provided to private health insurance through putting an end to further cost shifting.

5. The states would have substantially increased authority, within Federal guidelines, to control all health care costs within a state.

6. The plan would make possible the evolution of a program over the next two years which would establish a system through which in an orderly way health care costs could be contained. The frantic haphazard annual efforts by the Congress to effect needed savings would largely be avoided. Program planning and rationalization of services would be encouraged and would be related to necessary fiscal constraints.

7. The plan provides for comprehensive cost containment for the public and private sectors. It covers the principal elements which affect costs, hospitals, nursing homes, physicians and other professional providers, laboratory and X-ray services, health maintenance organizations, and new procedures and technology. It is based on the conviction that effective cost containment cannot be achieved by trying to save money in one sector, like hospitals, or in one program, like Medicare. This approach only results in shifting costs to the other elements or programs.

PROGRAM FEATURES

1. The plan would be implemented in two phases: (a) An immediate halt to permissable price increases beginning approximately 100 days after passage of the legislation. (b) A two year period for each state to develop the continuing cost containment mechanism and put it into operation.

If state were unable to develop a plan meeting the criteria in the legislation the Federal government would be authorized to step in.

2. Hospitals and nursing homes: In Phase I these institutions would be required to hold annual budgets and charges to the amounts expended in the previous year, or a model year in one of the past three years, plus the increase in the B.L.S. cost of living index for the previous year.

Adjustments for age, health status, intensity of care of patients, or other major changes which might affect costs would be made retrospectively by application to the state agency responsible for monitoring the plan.

In Phase II, after 24 months, a prospective budgeting system would be mandatory for hospitals and nursing homes on a state by state basis. The state would be required to hold total expenditures for each of the two programs to the previous year's expenditures within the state, plus the cost of living factor.

The states could, as long as they remained within the predetermined ceilings, use their own methods of determining how to pay hospitals within the system. This could be done in a variety of ways: Prospective budgeting by category of hospital (e.g. teaching hospital, small, medium or large community hospital, rural hospital, etc.); formulae to set limits on what could be charged various payors; budget reviews of each hospital; capitation payments for defined populations.

3. Physicians and other Professional Providers: Initially in Phase I fee schedules would be set at present levels in each of the three programs in the state (Medicare, Medicaid and private insurance). The only increases permissable would be a factor for the increase in overhead costs as reflected in the previous year's increase in the cost of living index.

In Phase II reimbursement arrangements, including fee schedules, would be based on negotiated agreements by the providers with the state agency. Representatives of

Medicare, the prepayment organizations and consumers would be part of the negotiations.

4. Laboratory and X-Ray Services: In Phase I the principle of present charges plus a factor for cost of living on the overhead costs would be followed.

In Phase II a laboratory and x-ray payment committee under the state agency, and consisting of representatives of the public agency, Medicare, laboratory and x-ray providers, insurance companies and consumers would negotiate annual reimbursement schedules. The Committee would be empowered to review appropriateness and frequency of the procedures and technology use.

5. Health Maintenance Organizations: The state agency would negotiate separate contracts with HMO's permitting maximum reimbursement up to prevailing costs in the area, or 95 percent of them, adjusted by age or health status.

Subsidies would be available, within these parameters, to encourage the development of new non-profit HMO's.

6. New Procedures—New Technology: A Professional Advisory Committee on New Procedures and Technology would be set up at the national level to advise the professions and the states on the appropriateness of new technology and the effectiveness of alternative therapeutic regimens. This committee could be either in the Department of Health and Human Services or the Institute of Medicine of the National Academy of Science.

7. Long Term Care: States would be authorized to use up to a stipulated percentage of Title XX funds and a percentage of Medicaid funds to support demonstration projects designed to maintain the chronically ill and severely disabled outside institutions, where appropriate.

Mr. Chairman this is a realistic and achieveable cost containment program which protects beneficiaries and patients. It is based on accepted principles in health care, including several incorporated in part in recent proposals by the American Hospital Association and the Health Insurance Association of America.

The principal drawback to this plan is that it does not extend eligibility for care to tens of millions of Americans without such needed protection. It also does not provide for new urgently needed life saving benefits like prescription drugs for the elderly. We hope and believe that at some point in the not too distant future the Congress will recognize that a universal national health insurance plan needs to be returned to a high place on the agenda of our national priorities.

Chairman JACOBS. Mr. Glasser, as for the proposal by which indexing takes place on present costs to the providers, had you thought through an amnesty over any inequities that might exist now in the reimbursement system?

Is it your proposal that we not hash over who's right, who's wrong, who's getting too much, who's getting too little and just go with what we have?

Does that strike you as a problem?

Mr. GLASSER. It strikes our committee as being very much of a problem, you are right. The States will need time to work this out. But we don't have time.

What we are proposing therefore is that in the first phase of 2 years, an immediate halt is called to increases, only increases reflecting the cost-of-living factor could be added. During the 2 years of phase I in negotiations between each State and the providers, there would be adjustments made to take care of the inequities you quite properly call to our attention.

Further, other adjustments will need to be made because of mix of population, more elderly people in one State than another, et cetera, but these would be done in an orderly fashion through negotiation.

Chairman JACOBS. Well, I express on behalf of many of the members of the committee, all members of the committee, our appreciation for your contribution and many members of the committee an intrigue and interest in what you are offering.

You have done a good service to the public, as well as your immediate membership.

Mr. GLASSER. Thank you very much.

Chairman JACOBS. We thank you both.

Mr. GLASSER. Thank you.

Chairman JACOBS. You are not going to win the time contest, Mr. Glasser.

The next panel consists of the National Governors' Association, Richard Curtis, associate staff director for Health Policy on behalf of the Honorable Scott Matheson, Governor of Utah; and Harold A. Cohen, executive director, Health Services Cost Review Commission, State of Maryland.

STATEMENT OF HON. SCOTT M. MATHESON GOVERNOR, STATE OF UTAH, AS PRESENTED BY RICHARD E. CURTIS, ASSOCIATE STAFF DIRECTOR FOR HEALTH POLICY, NATIONAL GOVERNORS' ASSOCIATION

Chairman JACOBS. Mr. Curtis, you may proceed.

Mr. CURTIS. As you mentioned, I am here to present the testimony of Governor Matheson. Again, I am Richard Curtis, associate staff director for Health Policy for the Governors' Association.

The Nation's Governors believe that current Federal medicare hospital reimbursement policies are a major cause of hospital cost increases facing the States and the private sector.

Excessive hospital cost escalation is of concern to Governors because of the effect on State medicaid costs, reduced economic productivity resulting from the diversion of scarce resources to the health care sector, and the impact on individuals paying directly for their medical care.

To address excessive health care cost escalation, the Governors support measures to improve market discipline in the health care sector, such as limiting tax exemptions for employer contributions to employee health plans.

We also believe that prospective hospital reimbursement policies that encourage efficiency and that do not subsidize waste must be adopted for the medicare program.

We would like to note, Mr. Chairman, that in the face of escalating health care costs driven by factors beyond our control, such as medicare hospital reimbursement policies and inflationary Federal tax subsidies for costly health benefits, the States are aggressively reducing medicaid costs.

The Congressional Budget Office estimates fiscal year 1982 cost increases of 6.2 percent in the State-administered medicaid program and 17.1 percent in the federally administered medicare program.

However, it will be increasingly difficult to contain medicaid expenditures if hospital costs continue to escalate at a rate of 18 percent per year. Medicaid program expenditures constitute less than a tenth of the hospital market, and are, therefore, subject to hospital cost escalation that is driven by the reimbursement policies of other payors.

In Utah, medicaid is only about 4 percent of the hospital market. Medicare determines reimbursement rates for 35 percent of total community hospital revenues according to Paul Ginsberg of CBO.

Because of medicare's dominant market role, Federal cost-based, retrospective reimbursement policies contribute greatly to hospital cost inflation by providing little incentive for efficiency, and often encouraging or subsidizing waste.

These Federal policies must be revised completely if States and other relatively small payors are to realize reductions in hospital cost increases.

The principal reason for the continuing escalation of medicare costs is not increases in beneficiaries or expansions in service coverage, but medicare hospital reimbursement policies.

The American Hospital Association's proposal for prospective payments indicates a recognition that these Federal policies must be changed.

The Federal Government can no longer afford to say to hospitals that the less cost-conscious they are and the greater the unnecessary costs they generate, the more they will be reimbursed by the taxpayer.

The Governors strongly believe that these retrospective cost-based policies must be replaced by prospective reimbursement policies that encourage efficiency and that do not subsidize waste.

We urge Congress to adopt an interim prospective, incentive-based approach to controlling medicare hospital expenditures beginning in fiscal year 1983. This will contribute substantially toward the budget savings the Congress has indicated for the medicare program.

The system should include measures that prohibit the shifting of excess costs to other payors. States should have the option to adopt the system for purposes of determining reimbursement levels under medicaid.

States with effective hospital reimbursement programs should be encouraged to establish rates of reimbursement of medicare. During the period that this interim approach is in place, the Federal Government should collect the necessary data to design and implement a permanent cost-effective reimbursement system.

State staff have developed a specific proposal for such an interim system consistent with NGA policy. Dr. Harold Cohen, executive director of the Maryland Health Services Cost Review Commission, played a key role in the development of this plan.

He is here today to describe the proposal to the subcommittee. We appreciate the opportunity to present our views with respect to medicare hospital reimbursement.

STATEMENT OF HAROLD A. COHEN, EXECUTIVE DIRECTOR, HEALTH SERVICES COST REVIEW COMMISSION, STATE OF MARYLAND

Mr. Cohen. Mr. Chairman, thank you for the opportunity to speak to you today regarding the question of how to contain medicare expenditures in the next year and in the future.

For that past 10 years, I have been executive director of Maryland's Health Services Cost Review Commission. The State of Maryland began regulating hospital rates in 1974.

In 1977, we entered into a contract with the Health Care Financing Administration. The contract provided funds for special studies and general operations, and most importantly, a waiver of medicare and medicaid reimbursement principles.

Since July 1, 1977, all payors have been paying Maryland's hospitals according to rates set by the commission.

The commission's law states that commission rate "orders shall be prospective in nature" (see 568W(a)(5)) and requires the commission "to assure all purchasers of health care hospital services that the total costs of the hospital are reasonably related to the total services offered by the hospital; that the hospital's aggregate rates are reasonably related to the hospital's aggregate costs; and that rates are set equitably among all purchasers or classes of purchasers of services without undue discrimination or preference."

Thus, Maryland's system is one of prospective rates covering all payors and assuring efficiency, solvency and equity.

We, as well as other HCFA-sponsored experiments, have demonstrated certain principles that can be applied on a national level to help contain medicare expenditures.

First, limiting hospital revenues through a prospective payment method does lead hospitals to spend less money. From fiscal year 1975 to fiscal year 1981, Maryland's hospitals, for example, have had increases in cost which average 2 to 3 percent a year less than the national rate of increase.

This cumulative saving of about 17 percent has occurred with no bankruptcies, with increased overall fiscal health and with maintenance of a very new—if overly large—capital base.

The system should allow hospitals to make profits it they contain costs. Some tables are attached.

Second, hospitals respond to incentives in the payment system. Thus, a system must not merely be designed to provide a flow of funds, but must be designed so that desired changes in hospital behavior improve the hospital's financial condition while hospitals are at financial risk for the cost associated with undesirable behavior.

Thus, market-type incentives are expressly designed as a kind of "visible hand" to replace the misincentives which are associated with cost-based reimbursement.

They should also lessen the effect of the misincentives associated with fee-for-service medicine and low out-of-pocket costs.

The most important system design issues in this regard are the unit of payment, how volume changes are treated by the payment system, and how hospital cost savings or overspending influence current or future revenues.

Maryland, New Jersey, and Rochester have all shown that the volume of hospital services must be measured at least as broadly as by the number of admissions.

That payment unit gives hospitals incentives to shorten length of stay and reduce ancillary testing. A broader unit of service, such as the community's population or number of Medicare eligibles served, provides better incentives regarding the number of admissions.

If admissions are used as the measure of volume, only variable costs—and probably a low estimate of them—should be used to adjust a hospital's total payments.

Hospitals can influence admissions and marginal costs are not great in the short run. I would support 100 percent variable cost if the payment unit were eligible subscribers.

That is, most likely, how a voucher system would work.

Under cost-based reimbursement, a hospital is not fiscally responsible for anything. If it spends more, it gets more.

Section 223 limits are very loose and most hospitals can ignore them.

They also drift upward with realized, rather than appropriate, increases in costs. Under a completely "prospective" payment system, a hospital would be totally at risk for all financial deviations.

For example, if the actual rate of inflation proved to be different from that projected, hospitals would be at risk for the misprojection.

We do not believe hospitals should be held at risk for such things as the unforeseen and unprojected increase in the price of X-ray film which occured in 1979. An adjustment has to be made for such unprojections.

We believe wherever possible, that inflation proxies from outside the hospital industry should be used as the measure of inflationary pressure in the marketplace. This is most important in the choice of the proxy for labor cost inflation.

Third, other regulatory systems which have been designed to respond to the misincentives of cost-based reimbursement should be eliminated or altered to make them complementary to the prospective system which is adopted.

For example, if the payment unit is the medicare population, PSRO's are inappropriate unless you want them to monitor quality.

If the payment unit is the admission, then length of stay review is inappropriate but strengthened preadmission review may be appropriate.

Fourth, a particular hospital's costs are not an acceptable basis for establishing its succeeding year's appropriate costs during the early years of its life.

We recommend that new hospitals, as well as hospitals less than 4 years old, have rates set based upon appropriate cost averages.

Fifth, hospitals respond to partial revenue constraints by "cost shifting" or attempting to increase revenue from other sources.

Cost reductions are usually the least likely management response. A medicare-only system can reduce medicare's expenditures. But it is not likely to significantly reduce the rate of increase in the percentage of our scarce resources going to hospital care unless you, the Congress, do something to make other payors more resistant to cost shifting.

I strongly urge you, both for a short-term and long-term solution to the resource problem, to change the tax laws so that wage payments and fringe payments are treated equally and so that hospitals must compete for renovation and expansion capital on equal footing with other American industries.

My testimony includes a specific proposal for controlling medicare expenditures which embodies the considerations discussed above.

This proposal, which also conforms to the broad criteria endorsed by the National Governors' Association, was developed by Graham Atkinson, Jack Cook, Jack Keane, Steve Renn, Carl Schramm, and myself.

My testimony also includes some observations I prepared which evaluates the AHA's proposal from this perspective.

[The prepared statement follows:]

Statement of Harold A. Cohen, Executive Director, Health Services Cost Review Commission, State of Maryland

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE:

THANK YOU FOR THE OPPORTUNITY TO SPEAK TO YOU TODAY REGARDING THE QUESTION OF HOW TO CONTAIN MEDICARE EXPENDITURES NEXT YEAR AND IN THE NEAR FUTURE. FOR THE PAST TEN YEARS, I HAVE BEEN EXECUTIVE DIRECTOR OF MARYLAND'S HEALTH SERVICES COST REVIEW COMMISSION. THE STATE OF MARYLAND BEGAN REGULATING HOSPITAL RATES IN 1974. IN 1977, WE ENTERED INTO A CONTRACT WITH THE HEALTH CARE FINANCING ADMINISTRATION. THE CONTRACT PROVIDED FUNDS FOR SPECIAL STUDIES AND GENERAL OPERATIONS AND, MOST IMPORTANTLY, A WAIVER OF MEDICARE AND MEDICAID REIMBURSEMENT PRINCIPLES. SINCE JULY 1, 1977, ALL PAYORS HAVE BEEN PAYING MARYLAND'S HOSPITALS ACCORDING TO RATES SET BY THE COMMISSION.

THE COMMISSION'S LAW STATES THAT COMMISSION RATE "ORDERS SHALL BE PROSPECTIVE IN NATURE" (SEE 568W(a)(5)) AND REQUIRES THE COMMISSION "TO ASSURE ALL PURCHASERS OF HEALTH CARE HOSPITAL SERVICES THAT THE TOTAL COSTS OF THE HOSPITAL ARE REASONABLY RELATED TO THE TOTAL SERVICES OFFERED BY THE HOSPITAL; THAT THE HOSPITAL'S AGGREGATE RATES ARE REASONABLY RELATED TO THE HOSPITAL'S AGGREGATE COSTS; AND THAT RATES ARE SET EQUITABLY AMONG ALL PURCHASERS OR CLASSES OF PURCHASERS OF SERVICES WITHOUT UNDUE DISCRIMINATION OR PREFERENCE." (SEC. 568U9a)). THUS, MARYLAND'S SYSTEM IS ONE OF PROSPECTIVE RATES COVERING ALL PAYORS AND ASSURING EFFICIENCY, SOLVENCY AND EQUITY.

WE, AS WELL AS OTHER HCFA SPONSORED EXPERIMENTS, HAVE DEMONSTRATED CERTAIN PRINCIPLES THAT CAN BE APPLIED ON A NATIONAL LEVEL TO HELP CONTAIN MEDICARE EXPENDITURES.

FIRST, LIMITING HOSPITAL REVENUES THROUGH A PROSPECTIVE PAYMENT METHOD DOES LEAD HOSPITALS TO SPEND LESS MONEY. FROM FY 75 TO FY 81 MARYLAND'S HOSPITALS FOR EXAMPLE HAVE HAD INCREASES IN COST WHICH AVERAGE 2 - 3% A YEAR LESS THAN THE NATIONAL RATE OF INCREASE. THIS CUMULATIVE SAVING OF ABOUT 17% HAS OCCURRED WITH NO BANKRUPTCIES, WITH INCREASED OVERALL FISCAL HEALTH AND WITH MAINTENANCE OF A VERY NEW - IF OVERLY LARGE - CAPITAL BASE. THE SYSTEM SHOULD ALLOW HOSPITALS TO MAKE PROFITS IF THEY CONTAIN COSTS. SOME TABLES ARE ATTACHED.

SECOND, HOSPITALS RESPOND TO INCENTIVES IN THE PAYMENT SYSTEM. THUS, A SYSTEM MUST NOT MERELY BE DESIGNED TO PROVIDE A FLOW OF FUNDS, BUT MUST BE DESIGNED SO THAT DESIRED CHANGES IN HOSPITAL BEHAVIOR IMPROVE THE HOSPITAL'S FINANCIAL CONDITION WHILE HOSPITALS ARE AT FINANCIAL RISK FOR THE COSTS ASSOCIATED WITH UNDESIRABLE BEHAVIOR. THUS, MARKET TYPE INCENTIVES ARE EXPRESSLY DESIGNED AS A KIND OF "VISIBLE HAND" TO REPLACE THE MIS-INCENTIVES WHICH ARE ASSOCIATED WITH COST BASED REIMBURSEMENT. THEY SHOULD ALSO LESSEN THE EFFECT OF THE MIS-INCENTIVES ASSOCIATED WITH FEE-FOR-SERVICE MEDICINE AND LOW OUT-OF-POCKET COSTS.

THE MOST IMPORTANT SYSTEM DESIGN ISSUES IN THIS REGARD ARE THE UNIT OF PAYMENT, HOW VOLUME CHANGES ARE TREATED BY THE PAYMENT SYSTEM, AND HOW HOSPITAL COST SAVINGS OR OVERSPENDING INFLUENCE CURRENT OR FUTURE REVENUES. MARYLAND, NEW JERSEY, AND ROCHESTER HAVE ALL SHOWN THAT VOLUME OF HOSPITAL SERVICES MUST BE MEASURED AT LEAST AS BROADLY AS BY

THE NUMBER OF ADMISSIONS. THAT PAYMENT UNIT GIVES HOSPITALS INCENTIVES TO SHORTEN LENGTH OF STAY AND REDUCE ANCILLARY TESTING. A BROADER UNIT OF SERVICE, SUCH AS THE COMMUNITY'S POPULATION OR NUMBER OF MEDICARE ELIGIBLES SERVED, PROVIDES BETTER INCENTIVES REGARDING THE NUMBER OF ADMISSIONS. IF ADMISSIONS ARE USED AS THE MEASURE OF VOLUME, ONLY VARIABLE COSTS - AND PROBABLY A LOW ESTIMATE OF THEM - SHOULD BE USED TO ADJUST A HOSPITAL'S TOTAL PAYMENTS. HOSPITALS CAN INFLUENCE ADMISSIONS AND MARGINAL COSTS ARE NOT GREAT IN THE SHORT RUN. I WOULD SUPPORT 100% VARIABLE COST IF THE PAYMENT UNIT WERE ELIGIBLE SUBSCRIBERS. THAT IS, MOST LIKELY, HOW A VOUCHER SYSTEM WOULD WORK.

UNDER COST BASED REIMBURSEMENT A HOSPITAL IS NOT FISCALLY RESPONSIBLE FOR ANYTHING. IF IT SPENDS MORE IT GETS MORE. SECTION 223 LIMITS ARE VERY LOOSE AND MOST HOSPITALS CAN IGNORE THEM. THEY ALSO DRIFT UPWARD WITH REALIZED, RATHER THAN APPROPRIATE, INCREASES IN COSTS. UNDER A COMPLETELY "PROSPECTIVE" PAYMENT SYSTEM, A HOSPITAL WOULD BE TOTALLY AT RISK FOR ALL FINANCIAL DEVIATIONS. FOR EXAMPLE, IF THE ACTUAL RATE OF INFLATION PROVED TO BE DIFFERENT FROM THAT PROJECTED, HOSPITALS WOULD BE AT RISK FOR THE MISPROJECTION. YET, NO PROSPECTIVE SYSTEM COULD HAVE FORSEEN THE ACUTE RISE IN THE PRICE OF X-RAY FILMS WHICH OCCURRED IN 1979 AND NO REASONABLE SYSTEM WOULD HOLD HOSPITALS ACCOUNTABLE FOR THE ASSOCIATED UNDERFORECAST OF INFLATION. ACCORDINGLY, A "PROSPECTIVE" SYSTEM SHOULD NOT BE ONE WHICH SETS FUTURE RATES IN CONCRETE BUT RATHER ONE THAT SETS REVENUE CONSTRAINTS FOR EACH HOSPITAL AND ADJUSTS THEM ONLY ACCORDING TO PRE-ESTABLISHED METHODOLOGIES. A PARTICULAR HOSPITAL'S REVENUES WOULD, THUS, BE ADJUSTED ON A YEAR TO YEAR BASIS WITHOUT RECOGNITION OF ITS ACTUAL COSTS BEYOND THE SPECIFIC APPLICATION TO THE HOSPITAL OF THE PRE-ESTABLISHED METHODOLOGY (I.E., HOW TO HANDLE VOLUME CHANGES, CASE-MIX CHANGES, FUTURE INFLATION, MISFORECASTS OF PAST INFLATION, CERTIFICATE-OF-NEED PROJECTS, NEW GOVERNMENT REGULATIONS, ETC.). WE BELIEVE, WHENEVER POSSIBLE AND MOST CERTAINLY FOR LABOR, THAT INFLATION PROXIES FROM OUTSIDE THE HOSPITAL INDUSTRY SHOULD BE USED AS THE MEASURE OF INFLATIONARY PRESSURE IN THE MARKET PLACE. WE ALSO BELIEVE THAT THE SYSTEM SHOULD ATTEMPT TO RESPOND TO CHANGES IN CASE MIX SO THAT HOSPITALS DO NOT HAVE INCENTIVES TO TRIVIALIZE THEIR ADMISSIONS OR TO AVOID PARTICULARLY SICK PATIENTS WHOM THEY ARE MEDICALLY EQUIPPED TO TREAT.

THIRD, OTHER REGULATORY SYSTEMS WHICH HAVE BEEN DESIGNED TO RESPOND TO THE MISINCENTIVES OF COST BASED REIMBURSEMENT SHOULD BE ELIMINATED OR ALTERED TO MAKE THEM COMPLEMENTARY TO THE PROSPECTIVE SYSTEM WHICH IS ADOPTED. FOR EXAMPLE, IF THE PAYMENT UNIT IS THE MEDICARE POPULATION, PSRO'S ARE INAPPROPRIATE UNLESS YOU WANT THEM TO MONITOR QUALITY. IF THE PAYMENT UNIT IS THE ADMISSION, THEN LENGTH OF STAY REVIEW IS INAPPROPRIATE BUT STRENGTHENED PRE-ADMISSION REVIEW MAY BE APPROPRIATE. SIMILARLY, THE TYPES OF PROJECTS WHICH SHOULD BE SUBJECT TO HEALTH PLANNING/CON, AND THE EFFECT THESE AGENCIES DECISIONS SHOULD HAVE ON REVENUES, DEPENDS ENTIRELY ON THE PAYMENT SYSTEM USED. PROJECTS WHICH SIMPLY CHANGE THE WAY PATIENTS ARE TREATED SHOULD NOT ALTER PROSPECTIVE PRE-ADMISSION RATES.

PROJECTS DESIGNED TO IMPROVE HOSPITAL EFFICIENCY SHOULD NOT INFLUENCE PROSPECTIVE RATES. PROJECTS DESIGNED TO INCREASE CAPACITY, ALTER CASE-MIX, OR RENOVATE WHILE REMOVING CURRENT DESIGN INEFFICIENCIES ALL MIGHT

AFFECT PAYMENT RATES BUT NOT AS A SIMPLE PASS-THROUGH. IN THOSE CASES PLANNING AGENCIES MIGHT APPROVE A MAXIMUM IMPACT ON MEDICARE PAYMENT PER ADMISSION SO THAT HOSPITALS WERE HELD ACCOUNTABLE FOR THEIR PROMISES OF COST SAVINGS AND VOLUME PROJECTIONS.

FOURTH, A PARTICULAR HOSPITAL'S COSTS ARE NOT AN ACCEPTABLE BASIS FOR ESTABLISHING ITS SUCCEEDING YEAR'S APPROPRIATE COSTS DURING THE EARLY YEARS OF ITS LIFE. WE RECOMMEND THAT NEW HOSPITALS, AS WELL AS HOSPITALS LESS THAN FOUR YEARS OLD, HAVE RATES SET BASED UPON APPROPRIATE COST AVERAGES. FURTHER, WE BELIEVE THE HISTORICAL COST OF HIGH COST HOSPITALS IS NOT USUALLY AN ACCEPTABLE ESTIMATE OF APPROPRIATE FUTURE COSTS FOR THEMSELVES OR OTHER HOSPITALS. WE RECOMMEND THAT FUTURE PAYMENTS BE BASED ON PREVIOUS MEDICARE APPROVED COSTS.

FIFTH, HOSPITALS RESPOND TO PARTIAL REVENUE CONSTRAINTS BY "COST-SHIFTING" OR ATTEMPTING TO INCREASE REVENUE FROM OTHER SOURCES. COST REDUCTIONS ARE USUALLY THE LEAST LIKELY MANAGEMENT RESPONSE. A MEDICARE-ONLY SYSTEM CAN REDUCE MEDICARE'S EXPENDITURES. BUT IT IS NOT LIKELY TO SIGNIFICANTLY REDUCE THE RATE OF INCREASE IN THE PERCENTAGE OF OUR SCARCE RESOURCES GOING TO HOSPITAL CARE UNLESS YOU, THE CONGRESS, DO SOMETHING TO MAKE OTHER PAYORS MORE RESISTANT TO COST SHIFTING. I STRONGLY URGE YOU, BOTH FOR A SHORT TERM AND LONG TERM SOLUTION TO THE RESOURCE USE PROBLEM, TO CHANGE THE TAX LAWS SO THAT WAGE PAYMENTS AND FINANCE PAYMENTS ARE TREATED EQUALLY AND SO THAT HOSPITALS MUST COMPETE FOR RENOVATION AND EXPANSION CAPITAL ON EQUAL FOOTING WITH OTHER AMERICAN INDUSTRIES.

MY TESTIMONY INCLUDES A SPECIFIC PROPOSAL FOR CONTROLLING MEDICARE EXPENDITURES WHICH EMBODIES THE CONSIDERATIONS DISCUSSED ABOVE. THIS PROPOSAL, WHICH ALSO CONFORMS TO THE BROAD CRITERIA ENDORSED BY THE NATIONAL GOVERNORS' ASSOCIATION,WAS DEVELOPED BY GRAHAM ATKINSON, JACK COOK, JACK KEANE, STEVE RENN, CARL SCHRAMM AND MYSELF. MY TESTIMONY ALSO INCLUDES SOME OBSERVATIONS I PREPARED WHICH EVALUATES THE AHA'S PROPOSAL FROM THIS PERSPECTIVE.

THANK YOU VERY MUCH. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS.

TABLE 1

PERCENTAGE CHANGE IN HOSPITAL COSTS AND UTILIZATION RATES IN
MARYLAND, THE U.S., REGION, REGULATED AND NONREGULATED STATES FOR THE YEARS 1971-1980

	Maryland			United States			Region			Regulated States			Nonregulated States		
	71-75	75-80	71-80	71-75	75-80	71-80	71-75	75-80	71-80	71-75	75-80	71-80	71-75	75-80	71-80
Inpatient Cost/Capita	60.57	91.81	207.99	63.26	73.15	182.68	27.56	143.85	211.07	55.81	62.52	153.22	65.38	92.92	219.05
Cost/Capita	64.54	92.11	216.10	66.96	87.64	213.29	64.85	96.30	223.60	59.81	66.22	165.65	69.26	94.91	229.90
Inpatient Cost/Adm	53.22	67.19	156.18	53.33	80.60	176.91	20.21	126.33	172.07	54.58	75.34	171.03	53.41	87.38	187.46
Cost/Adm	56.90	67.50	162.81	56.81	82.47	186.12	55.35	82.19	183.03	58.52	63.57	159.30	57.02	89.31	197.26
Inpatient Cost/Day	55.21	63.06	153.08	60.39	83.19	193.80	59.41	132.38	194.09	57.50	61.41	154.22	61.54	91.11	208.71
Patient Days/1000	3.46	17.61	21.68	1.90	.84	2.77	1.23	4.93	6.22	9.95	-10.14	-.17	2.61	.95	3.58
EIPD Days/1000	6.00	17.83	24.91	4.10	2.42	6.63	3.42	6.40	10.04	1.47	2.98	4.49	4.78	2.39	7.28
Inpatient Adm/1000	4.86	14.71	20.29	6.47	2.84	9.49	6.12	7.74	14.33	.82	1.62	2.45	7.79	2.96	10.90
ALOS	-1.31	2.53	1.19	-4.35	-1.82	-6.09	-4.62	-2.60	-7.09	9.02	-10.62	-2.56	-4.85	-1.88	-6.63
BEDS/1000	3.64	10.54	14.57	4.30	-.23	4.06	4.04	2.97	7.13	-2.82	.49	-3.29	5.98	-.23	5.74

Sources: 1. American Hospital Association Hospital Statistics, 1972, 1976, and 1981 editions
2. U.S. Department of Commerce Bureau of the Census, "Preliminary Intercensal Estimates of the Polulation of States: 1970 to 1980", 1982.

EIPD - Inpatient Day Equivalents; as defined in Hospital Statistics, "An aggregate figure reflecting the number of days of inpatient care plus an estimate of the volume of outpatient services . . ."

Regional States: Delaware, Virginia, W. Virginia, Pennsylvania, New Jersey, District of Columbia

Regulated States: Connecticut, Massachusetts, Maryland, New Jersey, New York, Washington

TABLE 2

COMPARISON OF HOSPITAL COSTS AND UTILIZATION RATES IN MARYLAND TO THOSE IN THE UNITED STATES, REGION, REGULATED AND NONREGULATED STATES FOR THE YEARS 1971 - 1980

	Year	Maryland	United States	Region	Regulated States	Non Regulated States
Inpatient Cost/Capita	1971	87.43	97.47	96.10	126.75	91.13
($)	1975	140.39	159.13	122.59	197.49	150.71
	1980	269.28	275.53	298.94	320.96	290.75
Total Cost/Capita	1971	100.44	108.30	106.78	142.39	100.15
($)	1975	165.26	180.82	176.03	227.56	169.51
	1980	317.49	339.29	345.54	378.26	330.40
Inpatient Cost/Admission	1971	833.56	668.82	686.93	903.82	619.73
($)	1975	1,277.20	1,025.47	875.74	1,397.10	950.73
	1980	2,135.41	1,852.05	1,868.09	2,449.64	1,781.46
Total Cost/Admission	1971	958 1	743.13	763.26	1,015.53	681.02
($)	1975	1,503.31	1,165.30	1,185.72	1,609.82	1,069.34
	1980	2,517.97	2,126.28	2,160.24	2,633.24	2,024.38
Inpatient Cost/Day	1971	99.08	83.43	77.01	100.46	78.88
($)	1975	153.78	133.81	122.76	158.22	127.42
	1980	250.75	245.12	226.48	255.39	243.51
Patient Days/1000	1971	882.51	1,173.18	1,242.61	1,258.91	1,152.73
	1975	913.02	1,195.52	1,257.83	1,384.22	1,182.77
	1980	1,073.80	1,205.65	1,319.95	1,256.73	1,194.01
EIPD Days/1000	1971	1,013.80	1,298.11	1,396.95	1,417.44	1,269.64
	1975	1,074.65	1,351.36	1,433.93	1,438.26	1,330.32
	1980	1,266.31	1,384.12	1,525.69	1,481.10	1,362.07
Inpatient Admissions/1000	1971	104.83	145.74	139.90	140.21	147.06
	1975	109.93	155.17	148.46	141.36	158.52
	1980	126.10	159.57	159.95	143.65	163.21
Average Length of Stay	1971	8.42	8.05	8.88	8.98	7.84
	1975	8.31	7.70	8.47	9.79	7.46
	1980	8.52	7.56	8.25	8.75	7.32
BEDS/1000	1971	3.02	4.19	4.21	4.25	4.18
	1975	3.13	4.37	4.39	4.13	4.43
	1980	3.46	4.36	4.51	4.11	4.42

Sources: 1. American Hospital Association *Hospital Statistics*, 1972, 1976, and 1981 editions
2. U.S. Department of Commerce Bureau of the Census, "Preliminary Intercensal Estimate of the Population of States: 1970 to 1980; 1982

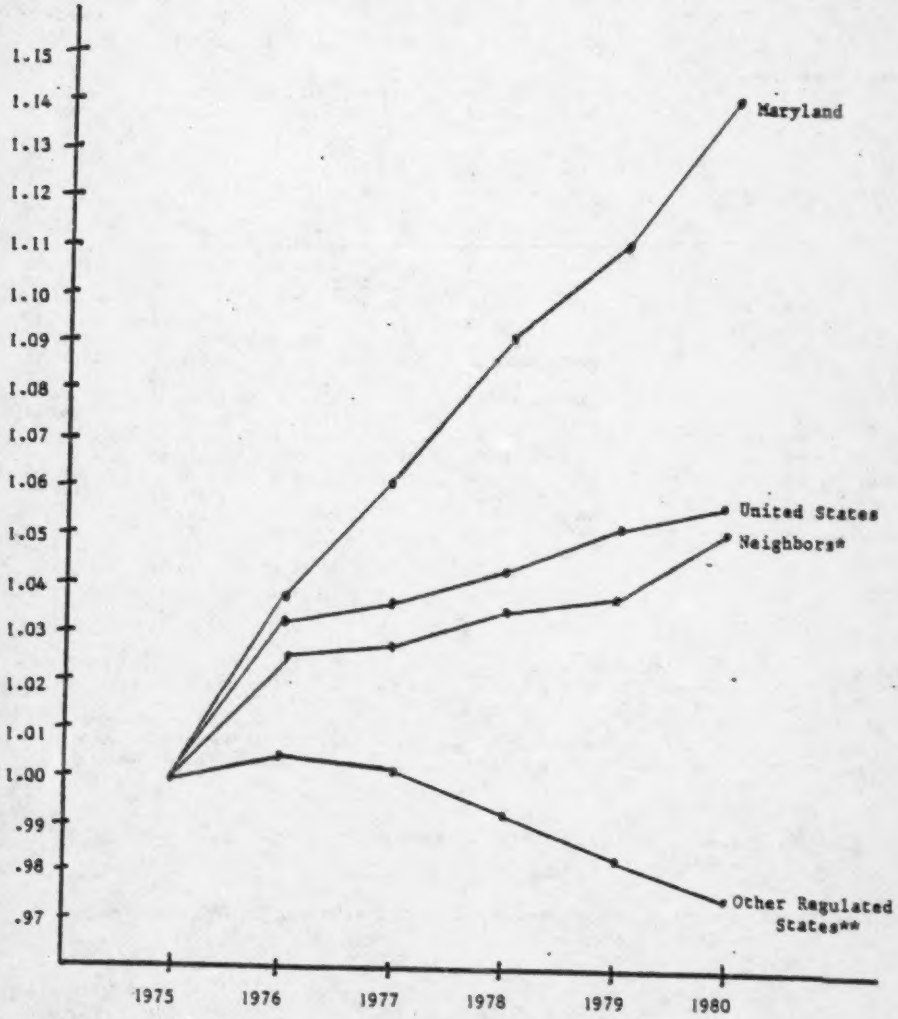
EIPD - Inpatient Day Equivalents; as defined in *Hospital Statistics*, "An aggregate figure reflecting the number of days of inpatient care plus an estimate of the volume of outpatient services . . ."

Regional States: Delaware, Virginia, W. Virginia, Pennsylvania, New Jersey, District of Columbia

Regulated States: Connecticut, Massachusetts, Maryland, New Jersey, New York, Washington

TABLE 3

TRENDS IN INDEX OF TOTAL BEDS FOR COMMUNITY HOSPITAL, 1975 - 1980



SOURCE: American Hospital Association, Hospital Statistics, 1976 - 1981

* Delaware, West Virginia, Pennsylvania, Virginia, New Jersey, District of Columbia

** Connecticut, Washington, Massachusetts, New York, New Jersey

TABLE 4

FULL TIME EQUIVALENTS OF REGISTERED NURSES

RN FTE'S PER THOUSAND EIPD'S

	Maryland	Other Regulated States*	United States	Neighbors**
1974	1.55	1.68	1.45	1.49
1975	1.71	1.75	1.53	1.59
1976	1.69	1.80	1.60	1.64
1977	1.84	1.86	1.69	1.73
1978	1.94	1.93	1.77	1.78
1979	2.01	1.98	1.84	1.90
1980	2.16	2.13	1.98	1.94

RN FTE'S PER THOUSAND EIPA'S

	Maryland	Other Regulated States*	United States	Neighbors**
1974	12.97	14.85	11.26	12.67
1975	14.24	15.52	11.80	13.28
1976	14.40	15.97	12.25	13.62
1977	15.60	16.33	12.89	14.34
1978	16.21	17.14	13.43	14.82
1979	16.82	17.41	13.90	15.64
1980	18.39	18.67	14.99	15.99

*Connecticut, Massachusetts, New Jersey, New York, Washington

**Delaware, District of Columbia, New Jersey, Pennsylvania, Virginia, West Virginia

SOURCE: American Hospital Association, Hospital Statistics, 1975-1981

TABLE 5

TRENDS IN MARYLAND HOSPITAL FINANCIAL STATUS

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	ANNUAL PERCENT GROWTH
BALANCE SHEET												
1 AVERAGE AVAILABLE BEDS	10499	10738	11018	11024	11214	11381	11737	11856	12383	12578	12613	1.85
2 CURRENT RATIO	1.61	1.60	1.77	1.77	1.64	1.62	1.54	1.56	1.51	1.50	1.62	0.06
3 CUR ASSETS/TOTAL ASSETS	0.20	0.21	0.22	0.21	0.22	0.23	0.23	0.23	0.22	0.22	0.23	1.41
4 UNREST FUND BAL/ASSETS	0.67	0.67	0.66	0.63	0.62	0.60	0.55	0.52	0.48	0.46	0.43	-4.34
5 TOT FUND BAL/TOTAL ASSETS	0.70	0.68	0.68	0.65	0.64	0.61	0.57	0.54	0.49	0.47	0.44	-4.54
6 LONG TERM DEBT/GROSS PPE	0.21	0.21	0.21	0.26	0.25	0.26	0.31	0.34	0.39	0.40	0.48	8.62
7 LONG TERM DEBT/NET PPE	0.29	0.28	0.30	0.37	0.36	0.38	0.46	0.50	0.57	0.59	0.70	9.60
8 UNRESTRICTED ASSETS/BED	39.17	42.12	43.87	49.02	50.81	55.45	61.39	68.32	77.54	85.03	97.19	9.51
9 TOTAL ASSETS/BED	45.56	46.79	48.47	53.41	55.94	60.99	68.26	74.98	84.94	89.63	100.33	8.21
10 LT DEBT/TOTAL FUND BAL	0.24	0.25	0.26	0.34	0.34	0.37	0.45	0.54	0.68	0.75	0.92	14.38
11 GROSS PPE/BED	36.19	38.65	40.38	44.71	48.07	54.17	57.34	64.07	72.05	78.49	85.92	9.03
12 FUND BALANCE/BED	26.39	28.23	28.97	30.85	31.75	33.39	33.96	35.84	36.90	39.46	41.71	4.68
INCOME STATEMENT												
13 OPER EXP TO OPER REVENUE	1.00	1.00	0.99	1.00	1.00	1.01	1.00	1.00	0.99	0.99	0.99	-0.10
14 OPER EXP TO TOTAL REVENUE	0.98	0.98	0.97	0.98	0.98	0.99	0.99	0.98	0.98	0.98	0.97	-0.10
15 OPERATING MARGIN	-0.17	0.30	1.00	-0.15	0.01	-0.50	0.04	0.44	0.51	0.89	0.86	
16 TOTAL MARGIN	1.84	2.43	2.95	2.28	2.05	0.90	1.29	1.73	2.18	2.43	2.83	4.40
COMBINED												
17 OPERATING REVENUE/ASSETS	0.70	0.77	0.84	0.81	0.87	0.96	0.99	0.99	0.95	0.96	0.95	3.10
18 TOTAL REVENUE/ASSETS	0.71	0.78	0.86	0.84	0.89	0.97	1.01	1.00	0.96	0.98	0.97	3.17
19 OPERATING REV/NET PPE	1.01	1.13	1.28	1.27	1.33	1.43	1.58	1.55	1.47	1.52	1.59	4.64
20 TOTAL REVENUE/NET PPE	1.03	1.16	1.30	1.30	1.36	1.45	1.60	1.57	1.50	1.54	1.62	4.63
21 OPER REV/LONG TERM DEBT	3.61	4.01	4.25	3.41	3.71	3.82	3.45	3.09	2.59	2.57	2.26	-4.58
22 TOTAL REV/LONG TERM DEBT	3.69	4.10	4.34	3.49	3.78	3.88	3.49	3.13	2.63	2.61	2.30	-4.62
23 WORK CAP/DAILY OPER REV	39.72	37.31	41.64	41.07	35.54	32.76	30.16	30.46	28.69	28.45	32.88	-1.87
24 CUR ASSETS/DAILY OPER REV	104.95	99.04	95.42	94.49	91.00	85.95	85.85	85.10	84.66	85.13	86.30	-1.94
25 CUR ASSETS/DAILY TOT REV	102.87	96.98	93.60	92.17	89.18	84.77	84.70	84.02	83.27	83.85	84.63	-1.93
26 CUR LIAB/DAILY OPER EXPEN	68.25	64.72	56.89	55.73	57.83	54.98	57.78	56.89	58.44	59.48	55.93	-1.96
27 OPER REVENUE/FUND BALANCE	1.04	1.15	1.27	1.29	1.40	1.59	1.80	1.88	1.99	2.07	2.22	7.88
28 TOT REVENUE/FUND BALANCE	1.06	1.17	1.30	1.33	1.42	1.62	1.82	1.90	2.02	2.10	2.26	7.86
29 EXCESS OF REV/FUND BAL	0.02	0.03	0.04	0.03	0.03	0.01	0.03	0.03	0.04	0.05	0.06	11.61
30 COMPOSITE AGE OF PLANT	7.22	7.27	7.04	7.74	8.20	8.55	8.52	8.78	8.18	7.95	8.09	1.14

Some Observations Regarding AHA Proposal
Medicare Prospective Fixed Price Payment to Hospitals

1. Introduction

The American Hospital Association has proposed a prospective payment system to replace the current cost-based methods of paying for Medicare inpatient care. The main thrust of the proposal is to eliminate the misincentives in Medicare's current system and to replace them with more appropriate incentives. This review looks at some of the incentives in the AHA proposal, its projections of levels of payments, and its basic cost containment potential.

2. Coverage

The following comments examine a number of the key "coverage" aspects of the AHA proposal.

(a) Payor Category

Unlike the ill-fated Carter hospital cost containment proposal, the AHA proposal seeks to establish a prospective system which is only binding on the Medicare program. This raises two important questions. First, can a Medicare-only system contain Medicare expenditures? Second, can a Medicare-only system contain total hospital expenditures?

The reported success of other hospital rate control programs which do not control all revenues suggests that a well-designed Medicare-only system could contain payments out of the Medicare Trust Fund. However, subsequent observations in this analysis will show that the AHA proposal is not likely to meet this objective.

Moreover, a Medicare-only system is not likely to reduce total hospital expenditures, or the share of the Gross National Product (GNP) being devoted to hospital care, if hospitals are left free to finance additional resource use by shifting costs to other patients or by increasing charges to Medicare patients. Congress must make cost-shifting more difficult if a Medicare-only program is to have a reasonable chance at containing costs. The most effective action to take in this regard would be to change the tax laws as they relate to private health insurance.

(b) Services

In addition to being limited to Medicare, the AHA proposal is limited to Part A services.(2) Since the basic methodology of the AHA proposal is to inflate historical Part A cost/discharge, and to pay this inflated cost for every budget year admission, any change of a service from Part A to Part B(3) will result in additional payments under Part B with no reduction in payments under Part A. For example, if a hospital decides to lease its laboratory or radiology departments to a physician, the service will stop being Part A and become a Part B service. While the AHA proposal appears to include a provision for correction when costs move from Part B to Part A, it does not correct for changes in the other direction.

(c) Inpatient Services Only

In addition to covering only Medicare Part A, the AHA proposal is confined to inpatient services. Medicare would continue to pay for outpatient services on a cost basis. It is common knowledge that hospitals have endeavored to allocate cost to inpatient areas rather than outpatient areas because of Medicare's comparatively high percentage use of inpatient services. Under the AHA proposal, hospitals would have a strong incentive to allocate future costs to outpatient areas, in order to receive the costs twice: once as part of their Part A inpatient cost base and again through cost-based payments for outpatient services. This perverse incentive would have the additional effect of shifting costs to Medicaid in hospitals in which Medicaid has a higher percentage of outpatient business than it has of inpatient business. These shifts could be substantial given the fact that Medicaid often has a greater outpatient penetration in costly urban teaching centers.

(d) Small Hospital Exemption

The AHA proposal would cover every hospital which is either in an SMSA or has 100 beds or more. Non-SMSA hospitals with less than 100 beds would have the option of choosing whether to receive prospective payments or cost-based reimbursement. The exemption of small hospitals is not inherently troubling, but it is nettlesome in this case because of the volume-related incentives which the AHA proposal gives to hospitals with overlapping service areas. Because the AHA methodology provides for discharge-based payments, determined by inflating full historical costs per discharge, an eighty (80) bed hospital opting into the prospective system would receive full inflated costs for every discharge in the budget year. If these discharges were drawn from a neighboring eighty (80) bed hospital which opted to remain on cost-based reimbursement, the latter hospital would lose no revenue unless they reflected their volume reduction in lower costs.(5) The potential for cost-shifting through patient-shifting makes it important to require that participation options be uniformly exercised within local hospital markets.

3. Base Costs

The AHA has proposed that actual base costs per discharge, without application of Sec. 223 limits or other cost or charge limits, be used as the foundation for establishing budget year rates. The Sec. 223 limits are currently very loose, and while applying them fairly and effectively is difficult, waiver of all attempts to exclude excess base year costs is of questionable merit. This policy would give an advantage to relatively "fat" hospitals over the term of the program. However, waiver of the lower of cost or charges limitation is reasonable where costs are reasonable.

The AHA proposal would be deficient in the case of new hospitals, hospitals with only one or two years of operating experience. These hospitals tend to show exorbitantly high costs per discharge while they are building volume levels. These hospitals are most likely to be above the Sec. 223 limits and to be caught in a "lower-of" cost or charges predicament. Therefore, it would make sense to provide that hospitals in this situation be subjected to the same limitation the

AHA proposes for brand-new hospitals - i.e., their costs should be limited by the costs of similar hospitals delivering similar services. Waiver of the "lower-of" limitation would also be appropriate in these cases.

4. Assignment/Non-Assignment

Medicare's handling of "assignments" has always been troubling because it permits physicians to make this decision on a patient-specific basis. In addition, there is some question about the appropriateness of Medicare's historical policy of contracting with hospitals which do not require hospital-based physicians, who effectively operate franchised monopolies, to accept universal assignment. Increasing the fiscal responsibility of Medicare patients is not necessarily bad policy, but hospitals should not have the right to accept unreduced Medicare program payments and bill patients an additional amount. The idea of copayment is to have the recipient of the service bear some of the cost so as to reduce the likelihood or magnitude of excessive resourse use. Copayment should be a sharing of reasonable cost between the insurer and the insured which gives the insured an incentive to a) not purchase inappropriate services and b) purchase appropriate services from cost-effective providers. The AHA proposal fails on all these counts. First, Medicare's payment is not reduced. The non-assignment option, while not lowering a hospital's receipts from Medicaid appears to give hospitals an opportunity to bill patients a surcharge which amounts to the difference between full charges and the current Medicare payment per discharge, up to a limit of $1,000 per beneficiary discharge. This provides additional resources of approximately 40% of the current Medicare payment per discharge. Unless carefully restructured, the AHA approach would shift the current protection provided by Medicare from the beneficiary to the hospital. While early Blue Cross plans were organized to protect hospitals, it seems clear from legislative history that Medicare was designed to protect elderly patients. Significant copayments could be used to induce more price-sensitivity, thereby protecting Medicare beneficiaries by protecting the Medicare Trust Fund, but these copayments should not be simple additions to Medicare program payments. For example, copayments could be structured in a way which would increase "out-of-pocket" payments when a beneficiary uses a hospital whose costs are higher than those of other hospitals providing the same services, and vice versa. This approach would have considerably different effects than the AHA proposal. In the AHA proposal low cost hospitals will receive the lowest per case rates and will have a greater need to charge "copayments". This feature could drive Medicare beneficiaries away from low cost hospitals and toward high cost, non-copayment facilities.

5. Basis of Payment

The following remarks address the basic incentives imbedded in the payment methodology proposed by the AHA.

(a) Payments Per Discharge

The AHA system provides for payments on a "per discharge" basis with no case mix adjustment and with 100% variable cost assumptions associated with increases or decreases in discharges. This amounts to a powerful incentive to increase admissions, particularly of the trivial variety because hospitals would receive their inflated average base cost per discharge for every budget year discharge. The presence of substantial fixed or relatively fixed costs in hospitals (e.g., depreciation, interest, certain overhead department costs, etc.) means that a 100% variable cost adjustment is likely to generate marginal revenues above marginal costs even with no change in case mix. If the new admissions were made up of patients with much less costly problems than those treated on average in the base year, the resulting "windfall" profits could be enormous. Given this fiscal environment, the competition for podiatrists and others generating short-stay, low cost admissions could be fierce. In addition, the incentive to shift from outpatient to inpatient surgery will be overwhelming. The AHA suggestion that these unprecedentedly strong utilization incentives can or will be counterbalanced by utilization review, most of which is to be done on a "deemed" basis, is overly optimistic if not patently wrong.

These incentives have implications regarding the validity of the AHA's projection of the cost impacts of its proposal. Despite the massive incentive to increase admissions, the AHA has forecasted that admissions will rise by only 2%. This runs at odds with Health Care Financing Administration (HCFA) and Congressional Budget Office (CBO) projections of a 3½% admissions increase under the existing Medicare payment rules which do not contain such powerful admission incentives. Regulatory programs, especially those with the weak sanctions available to utilization review agencies, do not work when their tasks are directly opposed to the financial interests of the regulated institutions.

Increased incentives to maintain or increase admissions are highly unlikely to produce fewer admissions. Yet, the AHA proposal ties approximately one-half of its projected savings to reductions in admissions.

(b) Inflation Factor

The AHA proposal is not specific in its recommendations for the calculation of inflation adjustments. Two observations are timely. First, any differences between the AHA and HCFA or CBO projections cannot be used to explain real differences in system expenditures - they merely reflect differences in forecasted expenditures. Second, both the AHA and HCFA inflation "market baskets" include wage rate indices which are drawn from the hospital market. This is circular methodological design of the most egregious type because indexing wages, which constitute 50-60% of hospital costs, to increases in hospital wages makes those wages a virtual "pass-through" at the aggregate level. Any prospective hospital payment system should use a non-hospital wage proxy to derive appropriate wage rate adjustments.

(c) Planning Adjustments

The AHA proposal gives hospitals 100% of inflated base year costs per admission plus a "pass-through" of planning-approved capital expenditure costs. However, many planning-approved projects are designed to increase a hospital's admissions capacity. Thus, paying for these increases through the 100% variable cost adjustment and through capital expenditure pass-throughs amounts to double payment.

In addition, some planning-approved projects are designed to permit hospitals to treat their existing case mix in new ways. Hospitals should not be paid 100% of the old way of treating patients plus 100% of the new way of treating patients. They should select the best way to treat patients within the inflated base year cost per admission constraint.

Another important variety of project which is not appropriately handled in the AHA proposal is "efficiency" projects. Under the previously low federal capital expenditures thresholds, many CON projects involved computerization of laboratories, computerization of billing systems, computerization of energy systems, installation of cheaper, in-house telephone networks, etc. These projects should produce net operating cost savings and should not result in higher rates. The AHA proposal would provide rate increases for these management choices. At a minimum, if certificate-of-need review is to be continued within this type of payment system, its focus should be consideration of the appropriate increase in Medicare payments per admission to be associated with any project.

The AHA proposal includes a number of other pass-throughs which are not troubling, although it should be recognized that some changes in federal regulations, etc. reduce operating costs on a net basis. The AHA proposal also provides that hospitals with relatively large Medicare/Medicaid volume be paid an additional amount, apparently to recognize the problems these hospitals would have in shifting costs to other payors. Certainly Medicaid and Medicare should be permitted to arrange higher payments to these hospitals, especially to finance re-development of a hospital-based physician payment system which permits inner city hospitals to attract hospital-based physicians. In hospitals with large percentages of relatively lucrative Blue Shield and commercial insurance coverage, physicians are willing to accept the franchise despite relatively low Medicare and Medicaid fee schedules. Medicare should be allowed to adjust its hospital-based physician payment methods to meet the special needs of inner city hospitals.

6. Miscellaneous

Another aspect of the AHA proposal which raises concern is the one-sided appeals process. Hospitals would be permitted to appeal without risk - i.e., they might get more money through an appeal but would never get less. This stimulates frivolous or poorly documented appeals, particularly when coupled with the provision that hospitals are deemed the "winners" when the appeal decision is not rendered within a stated timeframe. The provision that State waivers which encompass alternative reimbursement systems should be subject to cancellation by a simple unweighted hospital vote is unattractive and somewhat puzzling given the fact that all other votes by hospitals are to be conducted on a weighted basis. State governments should be permitted to decide whether an alternative reimbursement system should operate in their state.

7. Summary

The AHA's participation in efforts to reform the costly and outmoded Medicare reimbursement system is welcome and important to responsible adoption of necessary modifications. Cost-based reimbursement has led to excessive costs and utilization, and incentives should be changed to encourage more cost-effective services. These changes are especially crucial at a time when the hospital industry's grip on public resources is being loosened by other public demands. Unfortunately, the current AHA proposal needs major alterations before it can serve as a catalyst in efforts to create a most cost-effective health system.

REFERENCES

1. Biles, Brian et al. "Hospital Cost Inflation Under State Rate Setting Programs," in the New England Journal of Medicine; Coelen, Craig and Sullivan, Daniel. "An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures," in the Health Care Financing Review, Winter 1981.

2. Medicare "Part A" provides payments for hospital services.

3. Medicare "Part B" provides payments for physician services.

4. Standard Metropolitan Statistical Area, as defined by the U.S. Bureau of the Census.

5. The AHA proposal eliminates the Sec. 223 "routine cost limits" which would otherwise constrain the increases in costs per day which lower volumes would tend to produce.

A Short-Term Approach to Controlling Medicare Expenditures While Designing a Better Permanent System

This paper outlines a prospective, incentive-based approach to controlling Medicare hospital expenditures in Fiscal Year 1983 and Fiscal Year 1984. The proposed system would provide hospital-specific inflation and volume adjustments, a standard "intensity" adjustment, and an innovative state/regional "pool" of funds to cover major casemix changes, certificate of need (CON) projects and other items. The system would generate Medicare savings of approximately $1.2 billion or (4%) per year, or a cumulative $2.5 billion over the fiscal year 1983 - fiscal year 1984 period. The Department of Health and Human Services (DHHS) would be instructed to use the two year hiatus provided by this proposal to collect data and to design a permanent, population-based Medicare system which encourages market competition.

A. Background

Medicare expenditures are not currently subject to total spending limits. Costs incurred within allowable categories are paid, except for minor disallowances produced by Section 223 limits, etc. If a hospital's costs do not exceed these rather loose parameters, which float with the general upward spiral of hospital expenses, they can increase without restraint. The result of this open-ended financing scheme has been Medicare expenditures growth of 15% - 20% in recent years.

The Health Care Financing Administration (HCFA) is currently predicting Medicare hospital payment increases of 15.7% in Fiscal Year 1983 and 14.8% in Fiscal Year 1984. HCFA bases these overall projections on the following estimates of individual factors:

Factor	FY 1983	FY 1984
General Inflation	7.16	6.47
Excess Hospital Inflation	2.29	2.46
Volume	1.55	1.57
Intensity	2.68	2.44
Medicare Specific Factors	1.22	1.15

The current Medicare payment system and all the mandatory state rate settingprograms permit hospital costs to rise with general inflation. However, significant cost savings can be achieved by controlling some of the other factors. Elimination of "excess" hospital inflation, reduction of the questionable "intensity" effect, gradual limitation of new services and projects, and establishment of financial incentives tied to prospective spending limits can reduce Medicare spending by approximately 4% per year.

The next section provides an overview of a proposed "Medicare Payments Act of 1982"* which is a feasible, short-term approach to achieving necessary Medicare spending limitations.

B. System Overview

The proposed "Medicare Payments Act of 1982" is "prospective", (i.e. it sets spending targets for each hospital and for the Medicare program and adjusts only according to pre-established methodologies, etc.). If hospitals spend more than their allowed budget, they incur deficits; if they spend less, they make profits. The federal government benefits because the prospective spending targets are 4% less per year than the amounts which HCFA predicts the program would incur under cost-based reimbursement.

The "base" from which the prospective budgets are calculated is the Medicare basis of payment for the first fiscal year beginning on or after October 1, 1980. The Medicare basis of payment is the total allowable costs incurred by the hospital in allowable Medicare categories. This total amount - rather than Medicare's share of these costs - is trended forward using adjustments which account for inflation, volume, intensity, and the reasonable costs of certificate-of-need (CON) projects approved prior to 10/1/82 which are not fully reflected in the base year. In addition, State or regional "pools" of additional funds will be established to cover major casemix changes, substantial volume shifts, the net effects of changes in medical practice, and any other costs not covered in the hospital-specific adjustments. The pools would be operated by the fiscal intermediary at State level unless the Secretary approves a proposal by a Governor to operate the pool and/or to sub-divide his state for pooling purposes.

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*The proposed interim Medicare hospital reimbursement policies will be referred to as the "Medicare Payments Act of 1982"

The adjustments described above, when applied to the base costs, will produce the Allowable Cost Base (ACB) for each hospital for its first fiscal year beginning on or after 10/1/82. Thus, costs from Fiscal Year 1981 will have been trended forward to establish prospective budget amounts for fiscal year 1983. The allowable cost base will be reported in the format of the Medicare Cost Report. Medicare payments shall be calculated by applying standard Medicare apportionment techniques to the allowable Cost Base of the hospital.

In the second year (i.e., Fiscal Year 1984), the allowable cost base will be calculated by applying inflation, volume and intensity adjustments to the first year's allowable cost base, and adding any funds allocated to the hospital from the state pool. The pool shall be equal to 2% of the Allowable Cost Base for the previous year for all the hospitals in the state multiplied by the Medicare share determined using standard Medicare apportionment techniques.

C. Detailed System Description

The Medicare Payments Act of 1982 focuses on controlling the total "Part A" inpatient cost of hospitals. Medicare spending will be limited by allocating to Medicare only its proportionate share of the prospectively limited Part A hospital expenses.

The following paragraphs review the particular hospital-specific elements of the system, the pool distribution and other administrative features:

1) Hospital-Specific Adjustments

a) Base

The base from which future Allowable Cost Bases will be calculated will be the Medicare Cost Report filed for each hospital for the first fiscal year beginning on or after 10/1/80, adjusted to eliminate accruals and to account for the change in the Medicare nursing service differential. This cost basis will be adjusted to reflect Medicare audits and Section 223 disallowances in this base year. Section 223 limits will not be applied in years following the base year and the audit function will change somewhat to reflect the prospective nature of the system.

b) Inflation

The proposed system will adjust hospital costs to reflect inflation in hospital inputs as measured by indicators which track inflation in similar goods and services in the general economy. This approach holds hospitals accountable for keeping their input cost increases to levels experienced by other economic sectors. It is vitally important that Medicare not index its inflation adjustment to increases within the hospital sector. If Medicare were to base its inflation adjustment on the actual increase in hospital input costs (e.g., physician salaries), the hospitals would have no incentive to control (and strong incentives to increase) their input costs.

To accomplish the objective of holding hospital inflation to general inflation experience, the proposed system uses the HCFA "National Hospital Input Price Index" with several key modifications. First, non-physician payroll expenses should be tied to increases in the average hourly earnings of non-supervisory service workers in private enterprise as reported by the Bureau of Labor Statistics (BLS). Second, physician expenses should be adjusted by the lower of the non-physician index or the BLS index for professional employees. Third, building depreciation should be paid on an actual cost basis, subject to limits described elsewhere in this paper, and should not be inflated. These changes are expected to eliminate virtually all of the "excess" hospital inflation projected by HCFA to occur in Fiscal Year 1983 and 1984.

c) Volume

The basis for the volume adjustment will be total Medicare and non-Medicare admissions, excluding nursery admissions. The change in admissions will be computed from the base year, and the adjustment will be calculated as follows:

1) If admissions increase by an amount which is equal to or less than 2% of the base year admissions, there will be no cost adjustment.
2) If admissions increase by more than 2%, a cost adjustment equal to 50% of the base year non-capital cost per admission will be added to the base costs for each admission in excess of 2%.
3) If admissions decrease by an amount less than or equal to 5% of the base year admissions, there will be no cost adjustment; and
4) If admissions decrease by more than 5%, a cost adjustment equal to 50% of the base year non-capital cost per admission will be subtracted from the base costs for each admission lost beyond the 5% threshold.

This volume adjustment recognizes that hospitals can absorb small volume increases without incurring additional costs, that most volume increases above a 2% threshold can be handled at a 50% marginal cost, and that hospitals should be rewarded for reducing admissions.

d) Intensity

A major reason for hospital cost increases above inflation is an ongoing "intensification" of medical services. Intensity increases come in the form of increased staffing, increased technology, development and proliferation of costly new procedures, longer lengths of stay, increased use of established ancillary tests, etc. There is little evidence that these intensity trends have substantially increased the effectiveness of hospital care; in fact, the weight of the literature is on the side of those who argue that the intensity phenomenon has greatly increased costs without producing commensurate improvements in patient outcomes.

For these reasons, the proposed system reduces the projected HCFA allowance for intensity from 2.7% in Fiscal Year 1983 and 2.4 % in Fiscal Year 1984 to 2% in both years. The 2% amount is quite reasonable given the issues raised above and the fact that studies of underlying casemix intensity trends show an effect of about 1% per year. A lower allowance for intensity could be given, but this might be viewed as unfair to hospitals which increased intensity at the average historical rate during Fiscal Year 1982.

Thus, hospitals will be given an annual intensity adjustment equal to 2% of base year costs. This adjustment is intended to pay for changes in medical technology, small changes in casemix intensity, and the net effects of changes in medical practice (e.g., new procedures, more or less use of old procedures, tests, etc.). Hospitals can generate profits by holding their intensity increases below the somewhat generous 2% levels.

e) Summary of Hospital-Specific Adjustments in First Year

The base costs of the hospital will be adjusted first for changes in the volume of admissions between the base year (fiscal year 1981) and the first year (Fiscal Year 1983) using the previously described volume adjustment formula. The volume-adjusted base costs will then be adjusted by applying the inflation adjustment for the base-intermediate year to the volume adjusted base costs. This result, plus an intensity adjustment equal to 2% of volume adjusted base year costs and an adjustment to cover fiscal year 1982 CONs plus other CONS not fully reflected in the base year, equals the intermediate year allowable cost base (IYACB).(1) This intermediate cost base will then be adjusted by applying the intermediate-first year inflation adjustment to the IYACB and adding 2% of the IYACB to account for intensity changes. The result is the first year allowable cost base (FYACB).

2) Pool Adjustments

As stated in the System Overview, the hospital-specific adjustments described above will be supplemented by state/regional "pools" of funds. These pools will equal Medicare's proportionate share of 2% of the volume and inflation adjusted base year costs of the hospitals in each state or region. Half of the pool funds will be used to cover CON-approved capital and operating costs, and the other half will be used to cover major casemix changes and other costs not recognized in the hospital-specific adjustments.(2) The pools will be administered at a state level by the Medicare intermediary,(3) by a state agency or private corporation holding a federal Medicare waiver; or - at the request of the Governor of a state without a Medicare waiver - by any state agency, subject to approval from and regulations issued by the Secretary of DHHS. Governors would also have the option of sub-dividing their states for pooling purposes.

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(1) The actual costs of CONs would be subject to review by the intermediary or other administering agency.

(2) If states sub-divide into smaller areas for pool purposes, the option of combining the pool adjustments to an aggregate 2% would be given.

(3) In states with more than one Medicare intermediary, the the intermediary with the most hospitals will administer the pool.

The state/regional pools would be designed to cover the following costs:

a) Certificate of Need

Certificate of need projects not included in base year costs but approved prior to October 1, 1982 will be paid at approved levels and these costs will be subtracted from pool funds. If these costs exceed 1% but are within the 2% pool amount, the remainder of the 2% would be available for casemix and other changes. If these costs exceed 2%, no funds will be available in that year to cover non-CON costs covered in the hospital-specific adjustments. In recognizing CON costs, all projected operating cost savings reported in the CON/planning record will be removed from the allowable cost base. In addition, CON costs will be recognized at the lower of actual or approved levels. Hospitals will be held accountable for their CON volume projections as reflected in the CON/planning record.

CON projects approved after October 1, 1982 will be paid out of pool funds up to the 1% cost level. If CON project costs exceed the 1% level, all projects with net cost increases will absorb proportional reductions needed to bring total CON costs down to the 1% level. This limitation will encourage planning and CON agencies to make prioritized decisions regarding CON project need, cost, effectiveness, etc. In addition, it will prevent CON projects from consuming all funds available for other items, such as major casemix charges, which are often beyond individual hospital control. All costs of new hospitals approved after October 1, 1982 shall be paid from available pool funds on a reasonable cost basis not to exceed estimates made in the CON approval process.

b) Major Casemix Changes

Casemix changes which exceed 5%, as measured by using standard patient classification schemes and diagnostic resource weights, shall be eligible for payment from the state/regional pool. At the discretion of the Secretary, the 2% overall pool allotment may be increased for regions experiencing extraordinary volume increases caused by large population increases. The Secretary may also increase the pool to handle large increases in admissions in medically underserved areas.

c) Other Changes

Other costs not covered in the hospital-specific adjustments (e.g., casemix changes of less than 5%, the net effects of medical practice changes, new services, etc.) shall be paid from pool funds.

d) Summary of Pool Adjustments in First Year

Any pool distribution awarded to a hospital within the limits specified above will be added to the FYACB of the hospital. The result will be the first year payment base (FYPB). If the agency.

intermediary or corporation administering the pool allocates more funds to hospitals than allowed under this sytem, the allocated funds will be reduced on a pro rata basis until the total amount allocated equals the amount available in the pool. Pool funds not disbursed in the first year may be carried into the second year. Subsequent to the final settlements for the second year, remaining pool funds will be distributed by giving 50% to the hospitals, on a pro rata basis, 25% to the state, intermediary or corporation and 25% to the federal government.

3) Second Year Adjustments

Sections C(1) and C(2) have described the calculation of the first year payment base (FYPB) for the hospital. The second year payment base (SYPB) shall be calculated by adjusting the FYPB for inflation from the first year to the second year, for volume from the first year to the second year, and for an intensity increase equal to 2% of the volume adjusted FYPB. Adjustments for CON projects, major casemix changes and other non-hospital-specific cost factors will be made according to the procedures described above.

4) Calculation of the Medicare Liability

The Medicare liability shall be determined by applying standard Medicare cost apportionment techniques to the FYAB or SYPB. Thus, Medicare will pay its proportionate share of these cost bases at each hospital.

5) Interim Payments

Interim payments shall be made using estimates of inflation based on the most recently available inflation proxies available from the Bureau of Labor Statistics. Interim payments will not be adjusted for volume changes, CON project costs or other costs not covered in the hospital-specific adjustments, except at the discretion of the Secretary. In the event that volume changes, CON project costs, or other costs result in cost increases which are in excess of 10% greater than inflation-adjusted base year costs. The Secretary may increase a hospital's interim payments, subject to the overall system limits described in Section e(3).

6) Final Payments

The Final Payment shall be calculated on the basis of the applicable payment base using final inflation proxies. If the interim payments made to the hospital for the relevant year exceed the final payment, the difference shall be refunded by the hospital to Medicare. If the interim payments are less than the final payment, then the difference shall be paid by Medicare to the hospital.

D. System Development

The Medicare Hospital Payments Act of 1982 will require DHHS/HCFA/Medicare to use the Fiscal Year 1983 - 1984 period to develop a permanent Medicare payment system. A key task will be collection of all data needed to perform the base year cost analyses not included in the interim system. These data will include uniform hospital discharge data sets from all participating Medicare hospitals.

In addition, system development should be focused on methods of linking Medicare payments to Medicare beneficiaries, rather than to hospitals. By moving to a population-based approach, the Medicare system can create strong incentives to reduce unnecessary utilization, intensity changes, CON costs, and hospital input cost increases. These incentives could be strengthened by giving special advantages to health maintenance organizations and/or by giving Medicare beneficiaries a financial incentive to choose economical medical delivery plans.

E. Summary

This paper has outlined a feasible short-term approach to controlling Medicare hospital expenditures. Hospitals will be given inflation, volume and intensity adjustments plus state/regional "pools" to cover CON costs, major casemix changes, and other costs not covered in the hospital-specific adjustments. All budgets would be prospectively determined, with the consequent effect that hospitals would have strong financial incentives to control expenses in order to earn profits and avoid deficits. Expected savings would be approximately 3.2% in fiscal year 1983 and approximately 4.8% in fiscal year 1984.

Mr. **Anthony** [presiding]. I want to thank you very much.

If the United States could have as much success holding down increases in costs for health care, we would be way down the road. Hopefully, with your assistance, we will be able to get there.

I know the National Governors' Association have their own proposal. We will work with the staff, the staff will be analyzing that, and we will be working with you, also.

You have provided an excellent analysis. We think that you will be of utmost benefit to this committee as we try to find some of the answers that we need.

Thank you very much.

Mr. **Cohen**. Thank you very much.

Mr. **Curtis**. Thank you, Mr. Chairman.

Mr. **Anthony**. The next witness is Gail R. Wilensky, senior research manager, National Center for Health Services Research.

STATEMENT OF GAIL R. WILENSKY, SENIOR RESEARCH MANAGER, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

Ms. **Wilensky**. Mr. Chairman, it is an honor to appear before you today.

I am here as a researcher. Although I work for the National Center for Health Services Research and thus for the Department of Health and Human Services, I do not speak for the Department and my remarks should not be interpreted as such.

You have heard a variety of suggestions about how to affect expenditures on medicare in the short run. I would like to emphasize, along with Mr. Gephardt, the need for long-run efforts to lower the rate of increase in health care expenditures in general and Federal outlays in particular.

In doing so, I will be drawing on my own research. I am codirector of the National Health Care Expenditures Study, a comprehensive study of personal health care expenditures in the United States.

I recently completed an analysis on the Government's financing of health care, not only for those receiving direct support, but also for the rest of the population that is supported by indirect subsidies.

I would like to emphasize, as you have heard today, that there are two forms of Government expenditures. The direct programs of medicare and medicaid, and the indirect program of tax expenditures.

These are losses in Federal revenue that result from tax savings for certain types of taxpayers allowed under the Tax Code.

In particular, in health, they are the exclusion of employer-provided health insurance premiums from the employee's taxable income, and to a lesser degree, the deductability of certain medical expenditures from the individual's income tax returns.

This is not a new concept, nor is it unique to compare the tax expenditures on health with the amounts which have been spent on medicare and medicaid.

What I would like to do is to emphasize the distributional effects of these programs, particularly when you consider them together.

Medicare, as you know, has grown rapidly. In the period around the study period I looked at, 1975 to 1979, medicare was growing at about 17 percent a year; in the early eighties it looks as though it is growing at about 20 percent a year.

Medicaid has been growing at a slower rate during that period, about 13 percent in the 1975-to-1979 period.

The tax expenditures have been very hard to estimate because we have not had good data about them.

Using a very conservative estimate, it appears that during the period 1975 to 1979, tax expenditures grew at least at a rate of 19 percent per year.

There is strong indication that tax expenditures are continuing to grow at an even faster rate, in part because health insurance premiums continue to increase at a rapid rate and in part because inflation pushes individuals into higher and higher tax brackets.

But it is not just how fast these sources of revenue loss or expenditures are growing, but who's being affected by them that needs to be considered.

As part of the analysis I did, I looked at the American population, divided up into income groups which were adjusted for family size.

There are two ways that I would suggest people ought to look at the impacts of Government expenditures relative to the income distribution of the population.

First, on a per-capita basis, and second in terms of the blocks of dollars going to these different segments of the population.

When you look on a per-capita basis, you find tax expenditures increasing sharply as income rises, from $2 among the poor to $90 for the high-income group.

Medicaid expenditures fall sharply, from $184 for the poor, to $4 per capita for the rich. Medicare expenditures also fall, but not nearly as sharply.

Together, per capita expenditures by the Government decline as income increases from $327 per person for the poor to $142 for the high income.

But when you look at the blocks of dollars going to these different income groups, something else becomes apparent. Tax expenditures rise sharply as income increases, with 1 percent accruing to the poor, and 60 percent going to the high income.

Medicaid shows the opposite pattern: 62 percent to the poor, and 2 percent for the high income. The distribution from medicare is roughly proportional.

The inference from looking at these programs together is obvious. The distribution of medicaid expenditures favoring the poor is offset by the distribution of tax expenditures which in terms of premiums and other medical deductables favor high-income groups.

Together, it means the Government expenditures for these three programs together go in roughly equal proportions to the various groups of the population, the poor-, the middle-, and the high-income populations.

When you bring in the institutionalized population, which is important in considerations of medicaid, even then 50 percent of the three programs end up going to the middle- and high-income individuals.

The conclusions of the study are really four. First, that it is not enough to focus only on medicare and medicaid in attempting to curb Government expenditures on health.

Second, tax expenditures have been and are expected to continue to grow rapidly.

Third, they go to groups which normally are not considered first claimants on the Federal dollar, 50 percent at least going to the middle- and high-income populations.

Last, and perhaps most importantly, the tax expenditures provide a very strong incentive to buy more insurance than would be purchased otherwise which in turn is believed to exacerbate the rapid increase in the health care expenditures.

Given the variety of proposals which have been introduced into Congress to limit tax expenditues, I think that at least some individuals are beginning to recognize this point.

Thank you.

[The prepared statement follows:]

STATEMENT OF GAIL R. WILENSKY

Mr. Chairman and Members of the Subcommittee

It is an honor to appear before you today. I am here as a researcher. Although I work for the National Center for Health Services Research and thus for the Department of Health and Human Services, I do not speak for the Department and my remarks should not be interpreted as such.

The subject of the hearings today is a proposal to reduce expenditures on Medicare in fiscal years 1983 and beyond. Others are here to testify on specific ways to affect Medicare and other health expenditures in the short run. I would like to emphasize the need for long run efforts to lower the increase in health care expenditures in general and Federal outlays in particular. In doing so I will be drawing on my own research. I am co-director of the National Health Care Expenditures Study, a comprehensive study of personal health care expenditures in the United States. Using data from this 1977 study, I recently completed an analysis on the government's financing of health care, not only for those receiving direct support but also for the rest of the population that is supported by indirect subsidies.

It must be recognized that there are two forms of government expenditures for health care: The direct program of Medicare and Medicaid and the indirect program of tax expenditures. Tax expenditures consist of losses in Federal revenue resulting from tax savings for certain groups of taxpayers allowed by the tax code. The logic of calling these revenue losses "expenditures" is that a reduction in ax liability is equivalent to an expenditure in the same way that a forgiveness of debt is equivalent to a payment (CBO). In the case of health, losses in Federal revenue (and thus savings to tax payers) result from the exclusion of employer-paid health insurance premiums from their employees' taxable income, and from the deductibility of certain medical expenses for the purpose of computing personal income tax liabilities.

Regarding such tax expenditures on health as a major Federal program is not a new concept, nor is it unique to compare tax expenditures on health with the amounts spent on Medicare and Medicaid (e.g., Feldstein and Allison, Steuerle and Hoffman, Vogel). What I want to do here is to show the distributional effects of each of these programs. Sometime in the future, I hope to do an analysis of the redistributional effects from these programs, that is, expenditures less tax contributions used to finance them.

I. THE PROGRAMS

A. MEDICARE

Medicare, enacted in 1965 and effective as of July 1966, is a Federally administered scheme providing hospitalization and medical insurance for the population 65 years and older who receive cash benefits from social security or railroad retirement funds. In 1974, Medicare was extended to those under 65 years with chronic renal disease and to disabled persons receiving disability cash benefits for at least two years.

Medicare consists of two parts: a compulsory hospital insurance scheme (Part A) and a voluntary supplementary insurance scheme (Part B) which pays for physician services and some services and supplies not covered under Part A. In 1977, Part A had a deductible of $204 for the first 60 days of hospital stay and of $51 for the next 30 days. In 1977, Part B had a monthly premium of $11 and deductible of $60; it paid 80 percent of covered charges in excess of the deductible.

Medicare outlays have increased from $4.5 billion in 1967 to $15.6 billion in 1975 and $29.3 billion in 1979. The rate of increase was 15 percent in 1978 and 18 percent in 1979. In 1977, the year of interest in this paper, expenditures were reported as about $21 billion.

B. MEDICAID

Medicaid, also enacted in 1965, is the primary government program of medical assistance to the low-income population. It is Federally-State funded and administered at the state level but subject to Federal requirements and guidelines. There is a mandatory set of services which must be covered and a broad range of services which may be covered. Similarly, there is mandatory coverage of specific groups in the population; these include all persons eligible to receive cash assistance under the Aid to Families with Dependent Children program. Many states also cover those receiving cash assistance from Supplementary Security Income and the "medically needy," that is, persons who, although in one of the qualifying categories for cash assistance, have too much income to receive cash assistance but not enough to pay their medical bills.

While Medicaid is the primary program for the poor, many of the poor are not in fact covered. It has previously been estimated that two-thirds of the poor are not covered (Unpublished NMCES Data; Davis, Gold, and Makuc).

Federal expenditures on Medicaid were $1.2 billion in 1967, $7.1 billion in 1975, and $12.4 billion in 1979. Total expenditures on Medicaid were $12.3 billion in 1975 and $20 billion in 1979. A large part of this went to the institutionalized population; e.g., over 40 percent went to nursing homes. Expenditures for the noninstitutionalized population in 1977 were about $9.8 billion.

C. TAX EXPENDITURES

As stated before, the tax expenditures on health result from the exclusion of all employer-provided insurance contributions from their employees' taxable income and from the deductibility of certain medical expenses. The deductible applies to individuals who itemize deductions on their tax returns; they are allowed a deduction of 50 percent of the amount they pay for health insurance premiums, up to a maximum of $150, and a deduction of other medical expenses in excess of 3 percent of the taxpayers adjusted gross income (AGI), including all expenditures on drugs to the extent they exceed 1 percent of AGI. Two additional revenue losses are associated with the exclusion of employer-provided premiums from taxable income: States with an income tax loss revenue from excluding the employer contribution, and neither employers nor employees pay social security taxes on this income. The social security tax loss has not previously been considered part of the tax expenditure because the reduced tax results at least in part in reduced social security payments at a later date (Steuerle and Hoffman).

The value of the tax expenditure arising from the deductibility of medical expenses has been growing at an annual average rate of 7 percent. It was $1.5 billion in 1968, $2.3 billion in 1975, $2.5 billion in 1977, and $2.9 billion in 1979. Unlike these medical deductions from AGI, which are reported annually by the Internal Revenue Service, the revenue effects of the exclusion of employer-provided premiums are difficult to estimate, since tax payers are not required to list them on their tax forms. While estimates of total insurance premiums are readily available (they were reported to be $13.5 billion in 1967, $37.7 billion in 1975, $52 billion in 1977, and $66 billion in 1979; Health Insurance Institute), complete and reliable estimates of employer contributions to these premiums are more difficult to come by. According to results from a study using the Treasury tax model, the tax expenditure resulting from the exclusion increased from $1.1 billion in 1968 to $8.3 billion in 1979. In 1977 it was estimated to be $5.6 billion (Steuerle and Hoffman).

II. DISTRIBUTIONAL EFFECTS OF GOVERMENT HEALTH PROGRAMS

With the exception of the tax expenditures, the growth of the major Federal health programs has been well documented. What has not been well documented is their distributional effects. Attempts to analyze the distributional effects of all three of these programs have been hampered by lack of appropriate data. Some useful information is now available from the 1977 National Medical Care Expenditure Survey (NMCES), which provided detailed national data on Medicare and Medicaid recipients, expenditures paid by Medicare and Medicaid, family expenditures on health care, components of income, census family units, tax filing units, total premiums, and employer contributions in a single and internally consistent data set (Bonham and Corder).

A. A SUMMARY EXAMINATION OF DISTRIBUTIONAL EFFECTS

The distributional effects of the three major government programs on health--tax expenditures, Medicare and Medicaid--are shown in Table 1. The Medicaid expenditures shown here exclude expenditures on the institutional population. The U.S. population estimates also exclude the institutionalized population. The Medicare expenditures are shown net of Part B premiums and may be underestimated by about 15 percent. The U.S. population has been categorized by family income level and family income has been adjusted for family size. The poor include those whose family income was less than or equal to the 1977 poverty level as well as those whose income was between the 101 and 125 percent of that level. Other low income includes those whose income is 1.26 to 2 times the poverty level, middle income is 2.01 to 4 times the poverty level, and high income is 4.01 times the poverty level or more. For a family of four in 1977, these four groups distribute as follows: less than $8,000 to 9,999, $10,000 to 15,000, $16,000 to 31,999, and greater than $32,000. The percent of the population in each group is 14 percent, 15 percent, 39 percent, and 32 percent.

Table 1 shows per capita expenditures for each of the three programs. As one would expect, the tax expenditures per capita increase sharply as income rises, from $2 among the poor to $90 among the high income group. Medicaid expenditures fall sharply as income rises, from $184 to $4 per capita. Medicare expenditures also fall but not nearly as sharply. When all three programs are considered in conjunction, per capita expenditures decline from $327 per person for the poor to $142 per person for the high income group. If expenditures are limited to those who report receiving any benefits (not shown in Table 1), the distribution for Medicare becomes U-shaped, that is, higher for the poor and high income groups and lower for the middle income group. Medicaid expenditures decline inversely to income, with the steepest part of the curve observed for the high income group, which receives half of the amount of the lowest income group. Tax expenditures continue to rise with income.

Table 1 also shows total expenditure under each of the three programs as well as the distribution of expenditures across income groups. As expected, tax expenditures rise sharply as income increases, with 1 percent of the $10.3 billion total accruing to the poor and 60 percent to the high income group. Medicaid shows the opposite pattern: 62 percent go to the poor and 2 percent to the high income group. The distribution of expenditures on Medicare is closer to being proportional although it peaks with the middle income group and bottoms with the other low income group. The inference from considering these programs together is obvious: the distribution of Medicaid expenditures favoring the poor is offset by the distribution of tax expenditure in terms of permiums and other medical deductibles, which favors the high income sector. Thus, government expenditure associated with these programs goes in equal proportion to the high and middle income population and the poor. It is the other low income group which benefits least.

B. SUMMARY OF FINDINGS

Government expenditures on health care have increased fourteenfold from 1960 to 1979. In addition, there has been a major shift in the level of government involvement, and Federal expenditures are now twice as high as state and local expenditures. There are two major direct programs for the aged and poor, Medicare and Medicaid. An additional but indirect program is tax expenditures on health, i.e., revenue losses (and thus individual tax savings) from the exclusion of employer-paid insurance premiums from taxable income and from the tax deductibility of certain medical expenses.

The growth of expenditures on Medicare and Medicaid has been well documented. Total government expenditures on Medicare in 1979 were about $29 billion, with an average annual growth rate between 1975 and 1979 of 17 percent. Total expenditures on Medicaid in 1979 were about $20 billion ($9.8 billion for the noninstitutionalized population), or an annual average growth rate of 13 percent. The growth in tax expenditures and the distributional effects of these three programs remain to be fully documented. According to a Treasury Department estimate, tax expenditures in 1979 were $11.1 billion, or an estimated annual growth rate between 1975 and 1979 of 19 percent.

Because appropriate data have not been available, studies of the distributional effects of these programs have been rare and have looked at these programs in isolation. Data from the National Medical Care Expenditure Survey (NMCES) can contribute to solving this problem. Preliminary analysis of these data has produced two important findings. First, earlier estimates of that portion of tax expenditures which results from the exclusion of employer-provided insurance premiums from personal income were too low. The Treasury estimate for 1977 was $5.6 billion; the NMCES estimate is $7.9 billion.

Second, when major government outlays on health care for the noninstitutionalized population include these tax expenditures, per capita expenditures decline with income but, overall, the government spends about the same on the poor and near poor as it does on the middle income and high income population. It is the other low income group which benefits least. It would appear, therefore, that tax expenditure favors the high income group as much as Medicaid favors the poor, while the distributional effects associated with Medicare are small. Furthermore, when adjustments are made to incorporate expenditures on the institutionalized population, the overall conclusion remains much the same. While one third is now shown as going to the poor, 50 percent of the more than $42 billion spent in 1977 goes to middle and high income persons.

These results suggest that attempts to curb government expenditure on health must focus on tax expenditures as well as on Medicare and Medicaid, since this component plays an important part in determining the distributional effects of overall government expenditures. In addition it appears that tax expenditures have been growing at a faster rate than Medicare and much faster than Medicaid. The cost of excluding employer-paid health insurance premiums from taxable income which was about $8 billion in 1977 may have been as much as $20 billion in 1981. However, the large revenue losses to the U.S. Treasury and to a lesser extent to

State governments is only one effect of the current tax treatment of employer contributions to health benefits. The second and more important effect is that by implicitly reducing the price of health insurance, it may have provided an incentive to purchase excessive amounts of health insurance, a trend which is thought to result in increased levels of health expenditures. Given the various proposals which have been introduced to limit the tax free component of employer-provided insurance, it appears this point is understood.

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Table 1. Major federal government expenditures on health, 1977

All persons	Per capita government expenditures: Income tax savings	Medicare[a]	Medicaid	Total federal[b]
Poor and near poor	$2	$141	$184	$327
Other low income	16	99	63	178
Middle income	43	57	16	116
High income	90	48	4	142

All persons	Total expenditures (in billions): Income tax savings ($)	Income tax savings (%)	Medicare[a] ($)	Medicare[a] (%)	Medicaid ($)	Medicaid (%)	Total ($)	Total (%)
Poor and near poor	0.1	1	4.3	28	5.6	62	10.0	29
Other low income	0.5	5	3.1	20	2.0	22	5.6	16
Middle income	3.5	34	4.7	31	1.3	14	9.5	27
High income	6.2	60	3.3	21	0.2	2	9.7	28
Total expenditures (in billions)	10.3	100	15.4	100	9.1	100	34.8	100

[a] Less Part B. premiums.

[b] Excludes expenditures from veterans programs and small federal programs.

Mr. ANTHONY. I would like to thank you for your testimony and the study you have conducted.

We will make sure that Congressman Gephardt gets a copy of it. You may have given him some valuable information:

The committee will be in recess long enough to cast a vote and come back.

[Recess.]

Mr. ANTHONY. The subcommittee will come back to order.

Our next panel includes the American Medical Association, represented by William C. Felch, M.D., past chairman, council on legislation, American Society of Internal Medicine, N. Thomas Connally, M.D., chairman, governmental activities.

Gentlemen, you are welcome to introduce the two gentlemen with you.

Dr. CONNALLY. This is Rich Trachtman on my right who is our ASIM representative in Washington for legislative affairs.

Dr. FELCH. This is Mr. Bruce Blehart of the AMA staff. I am Dr. Felch.

Mr. ANTHONY. Dr. Felch, you may proceed. You are the lead witness. You are welcome to proceed as you wish.

Your full statement will be accepted for the record and you may summarize or do as you see proper.

STATEMENT OF WILLIAM C. FELCH, M.D., MEMBER, AMERICAN MEDICAL ASSOCIATION, COUNCIL ON LEGISLATION

Dr. FELCH. I will do that, sir.

The American Medical Association fully appreciates the problems facing this committee in meeting the budget resolution instructions to cut expenditures in the medicare program. Indeed, it is safe to characterize what this committee faces as a classical dilemma; on one side is the mandated need to find dollar savings in the Federal budget and in the medicare program; on the other side is the legitimate concern to maintain access to the high quality of medical care now available to medicare beneficiaries.

The American Medical Association is concerned that medicare program changes that are accomplished through the budget process will mostly be short-term or piecemeal solutions.

Without a fundamental rethinking of how Government should be involved with health care in this country, medicare and other governmental health care programs will only become larger burdens that could further weigh upon the national economy.

For this reason the AMA has embarked on a long-range study of Federal health programs, with an ultimate goal being the development of a national health policy.

An integral element of the AMA's proposed national health policy study will be the role of both the Government and private sectors in the furnishing of and paying for health care.

We expect that the results of this study will suggest major reforms in the Government's role in the health care of the individual citizen.

While this study is being initiated by the AMA, we fully expect broad participation from the many sectors of the health care economy.

We expect to have wide representations—from business and labor, the public, providers and health insurors—so that the policies recommended will be broad in scope and reflect the many interests involved.

In addition, we would hope to have participation from both the congressional and executive branch of the Government.

The American Medical Association empathizes with the committee as it addresses the budget dilemma. In order to assist the subcommittee in its job of finding ways to reach budget targets, we have identified short-term budgetary savings in the medicare program to recommend to you.

As you consider medicare changes, we urge extreme caution against undue cost-shifting. Dollar savings that are made from one pocket that just generate commensurate expenditures from another pocket are, at best, illusory.

At worst, they can create hardships for some beneficiaries, a situation we all want to avoid.

In addition to this concern, it is important to recognize that the major financial expenditures under the medicare program are made for institutional care, with approximately 70 percent of all medicare reimbursements going for institutional care.

Because of the significant percentage of medicare dollars that go for institutional care, we have examined both the American Hospital Association proposal for prospective hospital reimbursement and the Health Insurance Association of America proposal to reform health care payments.

The American Medical Association has reviewed recent proposals that have been voiced to generate savings in the Medicare program.

There are 12 proposals and in the interest of time, I shall not read them to you. I shall be happy to try to answer any questions the committee members may have either about the short-term proposals or about our plans for a study of long-term national health policy.

Thank you.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSICIATION

Mr. Chairman and Members of the Subcommittee:

My name is William C. Felch, M.D. and I am a physician in the practice of internal medicine in the city of Rye, New York. I serve as a member of the American Medical Association Council on Legislation, and for two years I was Chairman of that Council. With me today is Bruce Blehart, Assistant Director of the AMA's Department of Federal Legislation.

The American Medical Association fully appreciates the problems facing this Committee in meeting the Budget Resolution instructions to cut expenditures in the Medicare program. Indeed, it is safe to characterize what this Committee faces as a classical dilemma: on one side is the mandated need to find dollar savings in the federal budget and in the Medicare program; on the other side is the legitmate concern to maintain access to the high quality of medical care now available to Medicare beneficiaries.

In dealing with the dilemma of program costs versus program benefits, it is essential to recognize that the Medicare program did not reach its current size with its attendant problems overnight. Virtually every Congress has seen fit to tinker with the program, and what we recognize as Medicare today is dramatically different from the program envisioned and created by its sponsors. Just as the expansion of the Medicare program itself has evolved over time, so has the escalation of program costs. We recognize, and it is important to note however, that all Medicare program cost increases cannot be considered in a negative light. In addition, a significant percentage of cost increases is attributable to the severe inflation that has beset our economy. Nevertheless, some cost increases have occurred without an equal return through better access to care, or a better quality of care.

The American Medical Association is concerned that Medicare program changes that are accomplished through the budget process will mostly be short-term or piecemeal solutions. The nation's experience with Medicare is but one example of a federal health program that is fraught with financial problems. Unfortunately, in many instances where government is involved with the furnishing of or payment for health care, financial problems seem to be the rule. Without a rethinking of how government should be involved with health care in this country, Medicare and other governmental health care programs will only become larger burdens that could further weigh upon the national economy. For this reason the AMA has embarked on a long-range study of federal health programs, with an ultimate goal being the development of a national health policy.

The problems surrounding the federal budget process recognize that our country is now confronted by finite resources. We have reached the end of a long journey during which sustained economic growth always smoothed over the need for making tough choices. We are now experiencing the agony of setting priorities in social policy, including medicine. More and more we as a nation will have to allocate and sacrifice, and ask ourselves not what is desirable but what is necessary. Let me give you some illustrations of the sort of medical policy questions this country is going to have to face:

- What should be the priorities by which we allocate funds among basic research, applied research, and the undergraduate education of physicians?
- What is the most beneficial mix of specialists and primary care physicians?
- High technology makes possible the treatment of certain afflications but at tremendous per capita cost. Which should have priority: heart transplants for the middle aged, for example, or expanded immunization programs for the young?
- Are the benefits structured properly in Medicare, Medicaid and private health insurance programs? Are we insuring too much, and thereby destroying incentives for taking individual responsibility for personal health?

An integral element of the AMA's proposed national health policy study will be the role of both the government and private sectors in the furnishing of and paying for health care. We expect that the results of this study will suggest major reforms in the government's role in the health care of the individual citizen. While this study is being initiated by the AMA, we fully expect broad participation from the many sectors of the health care economy. We expect to have wide representation -- from business and labor, the public, providers and health insurors -- so policy recommended is broad in scope and reflects the many interests involved. In addition, we would hope to have participation from both the Congressional and Executive branch of the government. We have already invited the Secretaries of the Department of Health and Human Services and the Department of Defense to be part of the study. Mr. Chairman, just as the AMA is here today to cooperate and help seek viable interim measures that will result in budgetary savings in the Medicare program, we hope that the Congress will, in an appropriate way, participate in a process that we hope will eventually redirect the Medicare program out of its current economic problems. We hope it will be possible to make the necessary short-term savings and changes now and have more basic long-term changes to recommend from the results of the policy study.

The American Medical Association empathizes with the Committee as it addresses the budget dilemma. In order to assist the Subcommittee in its job of finding ways to reach budget targets, we have short-term budgetary savings in the Medicare program to recommend to you. As you consider Medicare changes, we urge extreme caution against undue cost-shifting. Dollar savings that are made from one pocket that just generate commensurate expenditures from another pocket are, at best, illusory. At worst, they can create hardships for some beneficiaries -- a situation we all want to avoid. We strongly urge that the Committee consider this cost-shift problem in making its budget recommendations.

In addition to this concern, it is important to recognize that the major financial expenditures under the Medicare program are made for institutional care, with approximately 70% of all Medicare reimbursements going for institutional care. Because of the significant percentage of Medicare dollars that go for institutional care, we have examined both the American Hospital Association (AHA) proposal for prospective hospital reimbursement and the Health Insurance Association of America (HIAA) proposal to reform health care payments.

The American Hospital Association proposal for prospective reimbursement for hospital services, announced last April, has been projected by AHA as saving approximately $1 billion in its first year of implementation. We understand that this projected savings is now being challenged by the Congressional Budget Office, and that the program is undergoing further review by the AHA. The proposal is not in legislative form, and we will continue to analyze it as it develops. Nonetheless, there are many questions that are of major concern at this time.

We must point out, before discussing the AHA proposal further, that the AMA has supported prospective reimbursement mechanisms, in various forms, on an experimental basis, and we continue to do so. It is another thing, however, to propose a single prospective reimbursement mechanism, such as that proposed by AHA, to be imposed nationwide without any track record to justify it.

The AHA proposal could create serious inequities and disparities among hospitals and beneficiaries. It has the potential for creating a two-class hospital system, with disruption in the physician/patient relationship. In addition, the negotiation process contemplated at the end of the initial stage is fraught with problems and would place hospitals at severe risk of inadequate funding based on budget demands.

Six days ago the HIAA issued a four-part proposal designed to reform the nation's health care payment system. The proposal called for: (1) appointment of a Presidential commission on health care payment reform to make specific recommendations to Congress within one year; (2) federal legislation to allow insurers to join together to negotiate with hospitals to cut costs and seek lower charges for their policy holders; (3) establishment of state prospective systems to predetermine approved hospital revenues, encourage cost containment, and permit all payors, both government and private, to pay hospitals on an equitable basis; and (4) temporary short-term state-by-state limits on permissible hospital revenue increases with penalties imposed for a hospital whose revenues exceed its portion of those limits, and with hospitals in states which approve prospective payment systems also being exempt from these limits.

Mr. Chairman, in our view the proposal for a Presidential commission would duplicate activities contemplated under the national health policy review to be undertaken by the AMA. Moreover, the HIAA proposal looks to the single element of health care payment and fails to recognize other equally important issues, such as the actual delivery of health care.

Certain elements of the HIAA proposal appear to be little more than a reiteration of the discredited hospital cost containment plan that was considered by Congress during the Carter Administration. The basis for rejecting that program was its reliance on a massive regulatory program, and the imposition of arbitrary caps that failed to take into account differences among individual hospitals while maintaining inequities that exist in the current reimbursement system. Temporary short-term limits on hospital revenue increases, as suggested, would be a totally inappropriate measure. Such a program would actually have the greatest negative impact on those institutions that are currently operating on an efficient basis, as there would be little room for generating program savings.

Mr. Chairman, neither the AHA proposal as originally presented nor the HIAA proposal is an appropriate answer to Medicare's short- or long-range problems. In the American Medical Association long-range development of national health policy, we have asked both the AHA and the HIAA to join with us. Through such cooperation, we hope to be able to present Congress with a series of proposals that will work to resolve the short-term needs and offer solutions for the long-range needs. The reality of the long-range needs is clearly evident in the fact that over the fifty-year period of 1980 to 2030 the over-65 population is projected to increased from 25.5 million people to 64.9 million people.

BUDGET SAVINGS PROPOSALS

The American Medical Association has reviewed recent proposals that have been voiced to generate savings in the Medicare program. In an effort to help the Committee accomplish its task for the development of a FY 1983 budget, the American Medical Association recommends the following program changes:

Repeal Mandated State Facility Review

State facility review, as mandated in current law, has caused needless duplication, and elimination of unnecessary review would be an appropriate change in the Medicare program. Elimination of specific, nonduplicative review activity that would result in a diminution of the quality of care offered in the facility should be avoided.

Reimburse Inpatient Radiology and Pathology Services at 80% of Reasonable Charges

Physicians furnishing inpatient radiology or pathology services should be reimbursed on the same basis as other physicians, and we thus support the proposal that such services be reimbursed under Part B at 80% of reasonable charge. In supporting this proposal, we assume that physicians furnishing inpatient radiology and pathology services would not be mandated to accept Medicare assignment.

Initiate Medicare Coverage at First Full Month of Eligibility

The eligibility period would shift to the first day of the first month following the potential beneficiary's 65th birthday. The AMA supports this provision.

Application of the Health Insurance Tax to Federal Employees

At the present time many federal employees are eligible to participate in the Medicare program from previous employment, and many of the non-covered federal employees will eventually hold positions outside of the government service where they will also become eligible for participation in the Medicare program. Because of future participation in the program benefits, equity would justify a sharing of program responsibilities. There should not be a substantial outlay in additional Medicare expenditures because of this proposal, and the AMA supports it.

Modify Medicare Coverage for the Working Aged

The AMA supports modification to the Medicare program that will result in having employers maintain health care coverage on those employees eligible for Social Security benefits because of their age.

Indexing the Medicare Part B Deductible

The AMA supports the concept of indexing the Medicare Part B deductible amount. However, we are concerned that the use of the Consumer Price Index will not accurately project the actual cost of the increases in Part B expenses. We recommend that a more accurate indicator of such increases be used.

Elimination of the Provider Waiver of Liability for Uncovered Medicare Services

Current law authorizes payment to institutional providers of Medicare services for certain uncovered services or for services deemed medically unnecessary where they are furnished in instances where the provider could not have known that the Medicare carrier would disallow payment.

The AMA supports elimination of this waiver. This action would put institutional providers on the same basis as physicians when a decision is made to deny reimbursement because the service is either uncovered or deemed medically unnecessary. In addition, this provision could have the net result of actually making institutional providers more cognizant of the services that they are providing and whether or not those services are likely to be covered under the Medicare program.

Repeal of the PSRO Program and Elimination of Requirements for Utilization Review

The AMA supports the elimination of the federally mandated programs for utilization and peer review. These programs have resulted in inefficiencies and have been shown to cost more to operate than they have generated in program savings. In opposing the existing programs under Medicare for utilization review, the Association continues to support programs designed to ensure that patients receive high quality care. The AMA has adopted formal principles for voluntary medical peer review. In adopting these principles, the AMA House of Delegates recognized that "the obligation to assure the quality of medical care services rendered to patients remains the comprehensive and underlying concept of any set of principles for peer review." In addition, the AMA is now in the process of developing a program for the implementation of voluntary medical peer review.

Coinsurance for Home Health Services

The AMA supports the concept of coinsurance payments as a reasonable means to help promote appropriate utilization of heath care services. Coinsurance applied to services provided by home health agencies could foster appropriate usage, and, if reasonable, should not deter beneficial usage.

Three-Day Prior Hospitalization Requirement

Since its inception, the Medicare program has required three days of prior hospitalization before coverage could be extended for skilled nursing facility care. We have repeatedly pointed out that because of this requirement patients have faced needless and expensive hospitalization. This requirement should be eliminated.

Administrative Actions

Two regulations under consideration by the Health Care Financing Administration (HCFA), the Annual Hospital Report regulation, and the Revised Conditions of Participation for Skilled Nursing and Intermediate Care Facilities carry substantial price tags. According to HCFA, the Annual Hospital Report would cost $56 million for the first year and $37 million (in 1978 dollars) annually thereafter. The Revised Conditions of Participation for Skilled Nursing and Intermediate Care Facilities has a HCFA estimated implementation cost of $80 million. Withdrawal of these proposed regulations would save program costs. While a first-year savings of $136 million would be significant, there is a distinct possibility that even greater savings than this would be realized. The American Hospital Association has projected the cost of the Annual Hospital Report at between $124 and $248 million, and the American Health Care Association and the National Council of Health Centers have estimated the implementation cost of the Conditions of Participation at $534.8 million. As plainly evident, substantial savings in the Medicare program could be generated through a decision not to implement these regulatory changes, and such a decision would not result in any diminution of the quality of care available to program beneficiaries or cost-shifting.

Optometric Coverage for Aphakia

One provision of the 1980 Reconciliation Act that could, in our opinion, stand repeal is the authorization of Medicare coverage for the treatment of aphakia by optometrists. One projection of the potential for duplicate payments where a patient is treated for aphakia by both an ophthalmologist and an optometrist is $10 million a year. The American Academy of Ophthalmology has submitted information to Congress that the "program costs may actually run nearly $93 million per year." We urge that this provision be repealed.

CONCLUSION

Mr. Chairman, the American Medical Association appreciates the difficult task that is before you. We urge you to bear in mind that program changes made with the goal of short-term budgetary savings are not going to solve long-term needs of this nation. The American Medical Association is planning a comprehensive examination of the long-term problems and has committed itself to work for their solutions. This study is in its initial stages; as potential proposals are generated by this study, we will share them with you.

Mr. ANTHONY. Dr. Connally, you may present your testimony and we will then open it up for questions.

STATEMENT OF N. THOMAS CONNALLY, M.D., AMERICAN SOCIETY OF INTERNAL MEDICINE

Dr. CONNALLY. I am Dr. Thomas Connally, a physician in Washington and a member of the board of trustees for the American Society of Internal Medicine.

We believe it is essential that the cost of the medicare program——

Mr. ANTHONY. Sometimes our system is difficult, if you don't speak directly into the mike.

Dr. CONNALLY. Mr. Chairman, we believe the cost of the medicare program must be controlled. However, we believe that the cost of the medicare program will continue to escalate at a rapid rate unless fundamental changes are made in the way that health care is financed in this country.

Short-term proposals that would simply shift costs on to nonmedicare patients are clearly unacceptable. ASIM welcomes the American Medical Association's announced intention to develop recommendations for long-term change.

However, ASIM believes that it is essential that Congress begin now to promote a long-term, positive, incentive-based approach to reforming the health care system. The current system of health insurance has created perverse incentives that encourage hospitalization, which by its nature is more expensive than ambulatory care. Those incentives also unintentionally reward inefficiency, promote costly technical and surgical procedures instead of less costly and frequently more effective, personalized, caring and preventive services.

They discourage patients, physicians and hospitals from becoming actively involved in holding down health care costs.

ASIM believes that only by correcting these perverse incentives can health care costs be effectively controlled. The society has distributed its recommendations for reforming these perverse incentives to business and labor groups, professional organizations, insurers, the Reagan administration, and other interested organizations.

We have also met directly with representatives of the Business Roundtable and will be meeting with the AFL–CIO in the near future. I am submitting the complete set of these recommendations for inclusion in the written record of this hearing.

ASIM urges these groups as well as Congress to promote a national health policy that will:

One, create incentives for providing services in ambulatory instead of more expensive in-hospital settings. The current system of health insurance encourages physicians to hospitalize patients for services that could be provided at lesser cost in their offices by paying more for services provided in hospitals, by denying coverage for services provided in physicians' offices, and by placing high deductibles on services provided in the ambulatory setting while requiring little or no cost-sharing for in-patient services.

ASIM recognizes that medicare, unlike most private health insurance policies, provides benefits for office visits and other ambulatory services under part B, and requires some patient cost sharing for in-hospital services.

However, further changes are needed to encourage physicians to treat patients in the less expensive ambulatory setting. Congress can begin to remedy the current bias by amending the medicare law to equalize reimbursement for ancillary procedures provided in the ambulatory setting, by requiring appropriate patient co-payment for the first 60 days of hospitalization, and by instructing HCFA to allow reimbursement for any covered procedure regardless of the setting in which it is provided.

Two, we should develop more efficient methods of reimbursement for in-hospital services. ASIM strongly believes that the current cost-plus reimbursement system must be replaced with a prospective system that rewards efficiency and penalizes inefficiency.

Three, require or encourage patient cost sharing in all private and public health insurance plans. ASIM believes that first dollar coverage eliminates any economic incentive for patients or physicians to question the necessity of tests, procedures, days of hospitalization, or for patients to limit their demand for services that may not truly be necessary.

As mentioned previously, Congress should mandate appropriate medicare cost-sharing for the first 60 days of hospitalization and require cost-sharing for ancillary procedures provided by hospital-based physicians to hospitalized patients.

ASIM also supports enactment of a national health insurance program to cover the costs of catastrophic illnesses in order to limit patients' out-of-pocket expenses.

Four, reduce incentives for expensive technological and procedural care.

Medicare and other health insurance programs currently encourage high cost technological and procedural services, while discouraging physicians from spending more time with patients providing preventive counseling and other thinking and caring services. This is because procedural services are reimbursed at a disproportionately higher level than the latter cognitive services.

From my own practice experiences, I know that if I order large numbers of tests and procedures I will get paid and my patients will be reimbursed relatively more by medicare, but if I spend more time with my patients questioning the need for each test and procedure, I will get paid less for this cognitive service and my patients will be reimbursed relatively less.

Congress can begin to correct this disparity by (1) instructing HCFA to develop a modified reimbursement system, revise the medicare index between cognitive and procedural services, and (2) revising the medicare economic index to allow reimbursement for cognitive services to increase at a relatively faster rate than reimbursement for procedures.

Five, enact consumer choice legislation that would expand consumers' choice of insurance plans and limit employers' deductibility of contributions to insurance plans. However, we are concerned that medicare may not be the ideal place to begin implementation of this approach, since adverse selection, cost shifting, and increased administrative costs may occur. Consequently, we do not favor enactment of medicare voucher proposals at this time, but support enactment of consumer choice legislation for nonmedicare patients.

[The prepared statement follows:]

STATEMENT OF N. THOMAS CONNALLY, M.D., AMERICAN SOCIETY OF INTERNAL MEDICINE

MY NAME IS N. THOMAS CONNALLY, MD, AND I AM A PHYSICIAN IN PRIVATE PRACTICE HERE IN WASHINGTON, D.C. AND A MEMBER OF THE BOARD OF TRUSTEES OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE. I APPRECIATE THE OPPORTUNITY TO PRESENT THE VIEWS OF ASIM'S 17,500 INTERNIST MEMBERS ON WAYS TO REDUCE THE COSTS OF THE MEDICARE PROGRAM.

ASIM BELIEVES THAT IT IS ESSENTIAL THAT THE COSTS OF THE MEDICARE PROGRAM BE CONTROLLED. HOWEVER, WE BELIEVE THAT THE COSTS OF THE MEDICARE PROGRAM WILL CONTINUE TO ESCALATE AT A RAPID RATE -- UNLESS FUNDAMENTAL CHANGES ARE MADE IN THE WAY THAT HEALTH CARE IS FINANCED IN THIS COUNTRY. SHORT-TERM PROPOSALS THAT WOULD SIMPLY SHIFT COSTS ON TO NON-MEDICARE PATIENTS ARE CLEARLY UNACCEPTABLE. ASIM WELCOMES THE AMERICAN MEDICAL ASSOCIATION'S ANNOUNCED INTENTION TO DEVELOP RECOMMENDATIONS FOR LONG TERM CHANGE.

HOWEVER, ASIM BELIEVES THAT IT IS ESSENTIAL THAT CONGRESS BEGIN NOW TO PROMOTE A LONG TERM POSITIVE "INCENTIVE-BASED" APPROACH TO REFORMING THE HEALTH CARE SYSTEM. THE CURRENT SYSTEM OF HEALTH INSURANCE HAS CREATED PERVERSE

INCENTIVES THAT ENCOURAGE HOSPITALIZATION, WHICH BY ITS NATURE IS MORE EXPENSIVE THAN AMBULATORY CARE. THOSE INCENTIVES ALSO UNINTENTIONALLY REWARD INEFFICIENCY AND PENALIZE EFFICIENCY, PROMOTE COSTLY TECHNICAL AND SURGICAL PROCEDURES INSTEAD OF LESS COSTLY, AND FREQUENTLY MORE EFFECTIVE, PERSONALIZED CARING AND PREVENTIVE SERVICES, AND DISCOURAGE PATIENTS, PHYSICIANS AND HOSPITALS FROM BECOMING ACTIVELY INVOLVED IN HOLDING DOWN HEALTH CARE COSTS.

ASIM BELIEVES THAT ONLY BY CORRECTING THESE PERVERSE INCENTIVES CAN HEALTH CARE COSTS BE EFFECTIVELY CONTROLLED. THE SOCIETY HAS DISTRIBUTED ITS RECOMMENDATIONS FOR REFORMING THESE PERVERSE INCENTIVES TO BUSINESS AND LABOR GROUPS, PROFESSIONAL ORGANIZATIONS, INSURERS, THE REAGAN ADMINISTRATION, AND OTHER INTERESTED ORGANIZATIONS. WE HAVE ALSO MET DIRECTLY WITH REPRESENTATIVES OF THE BUSINESS ROUNDTABLE AND WILL BE MEETING WITH THE AFL-CIO IN THE NEAR FUTURE. I AM SUBMITTING THE COMPLETE SET OF THESE RECOMMENDATIONS FOR INCLUSION IN THE WRITTEN RECORD OF THIS HEARING. ASIM URGES THESE GROUPS AS WELL AS CONGRESS TO PROMOTE A NATIONAL HEALTH POLICY THAT WILL:

1. CREATE INCENTIVES FOR PROVIDING SERVICES IN AMBULATORY INSTEAD OF MORE EXPENSIVE IN-HOSPITAL SETTINGS. THE CURRENT SYSTEM OF HEALTH INSURANCE ENCOURAGES PHYSICIANS TO HOSPITALIZE PATIENTS FOR SERVICES THAT COULD BE PROVIDED AT LESSER COST IN THEIR OFFICES, BY PAYING MORE FOR SERVICES PROVIDED IN HOSPITALS, BY DENYING COVERAGE FOR SERVICES PROVIDED IN PHYSICIANS' OFFICES, AND BY PLACING HIGH DEDUCTIBLES ON SERVICES PROVIDED IN THE AMBULATORY SETTING WHILE REQUIRING LITTLE OR NO COST-SHARING FOR IN-PATIENT SERVICES. ASIM RECOGNIZES THAT

MEDICARE -- UNLIKE MOST PRIVATE HEALTH INSURANCE POLICIES -- PROVIDES BENEFITS FOR OFFICE VISITS AND OTHER AMBULATORY SERVICES UNDER PART B, AND REQUIRES SOME PATIENT COST SHARING FOR IN-HOSPITAL SERVICES. HOWEVER, FURTHER CHANGES ARE NEEDED TO ENCOURAGE PHYSICIANS TO TREAT PATIENTS IN THE LESS EXPENSIVE AMBULATORY SETTING. CONGRESS CAN BEGIN TO REMEDY THE CURRENT BIAS BY AMENDING THE MEDICARE LAW TO EQUALIZE REIMBURSEMENT FOR ANCILLARY PROCEDURES PROVIDED IN THE AMBULATORY SETTING, BY REQUIRING APPROPRIATE PATIENT CO-PAYMENT FOR THE FIRST 60 DAYS OF HOSPITALIZATION, AND BY INSTRUCTING HCFA TO ALLOW REIMBURSEMENT FOR ANY COVERED PROCEDURE REGARDLESS OF THE SETTING IN WHICH IT IS PROVIDED, AS LONG AS THE SETTING IS MEDICALLY APPROPRIATE.

2. DEVELOP MORE EFFICIENT METHODS OF REIMBURSEMENT FOR IN-HOSPITAL SERVICES. ASIM STRONGLY BELIEVEDS THAT THE CURRENT "COST-PLUS" REIMBURSEMENT SYSTEM MUST BE REPLACED WITH A PROSPECTIVE SYSTEM THAT REWARDS EFFICIENCY AND PENALIZES INEFFICIENCY.

3. REQUIRE PATIENT COST SHARING IN ALL PRIVATE AND PUBLIC HEALTH INSURANCE PLANS. ASIM BELIEVES THAT "FIRST DOLLAR" COVERAGE ELIMINATES ANY ECONOMIC INCENTIVE FOR PATIENTS OR PHYSICIANS TO QUESTION THE NECESSITY OF TESTS, PROCEDURES, OR DAYS OF HOSPITALIZATION, OR FOR PATIENTS TO LIMIT THEIR DEMAND FOR SERVICES TO WHAT IS TRULY NECESSARY. AS MENTIONED PREVIOUSLY, CONGRESS SHOULD MANDATE APPROPRIATE MEDICARE COST-SHARING FOR THE FIRST 60 DAYS OF HOSPITALIZATION AND REQUIRE COST-SHARING FOR ANCILLARY PROCEDURES PROVIDED BY HOSPITAL-BASED PHYSICIANS TO HOSPITALIZED PATIENTS. ASIM ALSO SUPPORTS ENACTMENT OF A NATIONAL HEALTH INSURANCE PROGRAM TO

COVER THE COSTS OF CATASTROPHIC ILLNESSES IN ORDER TO LIMIT PATIENT'S OUT-OF-POCKET EXPENSES.

4. REDUCE INCENTIVES FOR EXPENSIVE TECHNOLOGICAL AND PROCEDURAL CARE. MEDICARE AND OTHER HEALTH INSURANCE PROGRAMS CURRENTLY ENCOURAGE HIGH COST TECHNOLOGICAL AND PROCEDURAL SERVICES, WHILE DISCOURAGING PHYSICIANS FROM SPENDING MORE TIME WITH PATIENTS PROVIDING PREVENTIVE COUNSELLING AND OTHER THINKING AND CARING SERVICES. THIS IS BECAUSE PROCEDURAL SERVICES ARE REIMBURSED AT A DISPROPORTIONATELY HIGHER LEVEL THAN THE LATTER COGNITIVE SERVICES. FROM MY OWN PRACTICE EXPERIENCES, I KNOW THAT IF I ORDER LARGE NUMBERS OF TESTS AND PROCEDURES I WILL GET PAID MORE AND MY PATIENTS WILL BE REIMBURSED RELATIVELY MORE BY MEDICARE, BUT IF I SPEND MORE TIME WITH MY PATIENTS QUESTIONING THE NEED FOR EACH TEST AND PROCEDURE, I WILL GET PAID LESS FOR THIS COGNITIVE SERVICE AND MY PATIENTS WILL BE REIMBURSED RELATIVELY LESS.

   CONGRESS CAN BEGIN TO CORRECT THIS DISPARITY BY (1) INSTRUCTING HCFA TO DEVELOP A MODIFIED REIMBURSEMENT SYSTEM TO REDUCE THE DISPARITY IN REIMBURSEMENT BETWEEN PHYSICIANS' COGNITIVE AND PROCEDURAL SERVICES, AND (2) REVISING THE MEDICARE ECONOMIC INDEX TO ALLOW REIMBURSEMENT FOR COGNITIVE SERVICES TO INCREASE AT A RELATIVELY FASTER RATE THAN REIMBURSEMENT FOR PROCEDURES.

5. ENACT "CONSUMER CHOICE" LEGISLATION THAT WOULD EXPAND CONSUMERS' CHOICE OF INSURANCE PLANS AND LIMIT EMPLOYERS' DEDUCTIBILITY OF CONTRIBUTIONS TO INSURANCE PLANS. HOWEVER, ASIM IS CONCERNED THAT THE

MEDICARE PROGRAM MAY NOT BE THE IDEAL PLACE TO BEGIN IMPLEMENTATION OF THIS APPROACH, SINCE ADVERSE SELECTION, COST-SHIFTING, INCREASED ADMINISTRATIVE COSTS, AND RESTRICTIONS ON BENEFICIARY ACCESS TO MEDICAL CARE ARE MORE LIKELY TO OCCUR WITH MEDICARE THAN NON-GOVERNMENTAL INSURANCE PROGRAMS. THIS IS BECAUSE THE MEDICARE VOUCHER AMOUNT MAY BE SET AT AN UNREALISTICALLY LOW LEVEL TO REDUCE PROGRAMMATIC EXPENDITURES. CONSEQUENTLY, ASIM DOES NOT FAVOR ENACTMENT OF MEDICARE VOUCHER PROPOSALS AT THIS TIME, BUT WOULD SUPPORT ENACTMENT OF "CONSUMER CHOICE" LEGISLATION FOR NON-MEDICARE PATIENTS.

THANK YOU FOR THE OPPORTUNITY TO TESTIFY TODAY. I'D BE PLEASED TO ANSWER ANY QUESTIONS FROM THE COMMITTEE.

Toward an Incentive-Based Approach for Reforming the Health Care System:

Recommendations of the American Society of Internal Medicine

April 1982

Background

Controlling health care costs continues to be a major concern of government, health insurers, physicians and the public. Various strategies to reduce—or at least slow down—the rate of increase in health care costs have been suggested, most of which fall under proposals for increased regulation of health care delivery, promotion of more competition between insurance companies and individual providers, or for reducing health insurance benefits to patients.

The American Society of Internal Medicine (ASIM)—an organization of more than 17,500 physicians nationwide who specialize in internal medicine—has spent considerable time and resources in recent years studying the reasons behind the rapid escalation in health care costs and developing recommendations for making the system more cost-effective.

ASIM strongly supports the March 1982 statement by American Medical Association (AMA) President Daniel Cloud, MD, calling on all interested health groups to join the AMA "in viewing the overall situation with a long-term perspective," as he announced the AMA's intention to make recommendations for long-term policies to provide proper care to Americans within the available resources. ASIM intends to offer assistance and cooperation to the AMA in developing such solutions, but also believes there are a number of approaches to the issues of cost, quality and access that merit immediate consideration.

Based on both the real-life experiences of physicians in direct patient care and on an analysis of the socioeconomic factors that encourage cost escalation, ASIM has developed recommendations that it believes would constitute an effective national policy for moderating health care costs. The recommendations are based on one fundamental conclusion: **the current system of health insurance (coupled with well-intended but counterproductive federal regulations and policies) has created perverse incentives that encourage hospitalization, which by its nature is more expensive than ambulatory care. Those incentives also unintentionally reward inefficiency and penalize efficiency, promote costly technical/surgical procedures instead of less-costly (and frequently more effective) personalized caring services, and discourage patients, physicians and hospitals from becoming actively involved in holding down the costs of medical care.**

ASIM believes that only by correcting perverse incentives can health care costs be effectively controlled. The Society does not pretend that these are the only workable approaches and welcomes recommendations that the AMA and others may develop. ASIM is certain, though, that a positive "incentive-based" national health policy is essential and recognizes that implementation of these recommendations will require a major commitment by physicians, insurers, government and the public to change the traditional way things have been done. However, the Society believes "business as usual" is not acceptable and pledges that its members will continue to do their part to contain costs by participating in effective peer review and health planning programs, by supporting changes in the way patients are reimbursed for internists' and other providers' services, and by working to provide more cost-effective care. After all, Americans respond better to challenges and positive incentives than they do to unneeded sanctions and regulations.

ASIM will continue to study this problem and volunteer recommendations for change. The Society challenges all who are concerned with health care costs to work toward implementing these and other effective approaches to control costs while at the same time maintain and improve the quality of medical care.

Recommendations

In examining the overall system, attention naturally is focused on the major components and players. Forty percent of the nation's health care costs are spent in acute-care hospitals, with approximately 75 percent of those hospitals' revenues coming from federal funding or other cost-based insurance programs. Therefore, the institutional role played by patients, physicians, insurers and the general community must be carefully considered and evaluated. These thoughts are reflected in the following recommendations:

1. Create incentives for providing services in ambulatory instead of in-hospital settings.

Health care financing in this country currently is biased toward providing services in the most expensive setting: the hospital. However, many of the services now provided in the hospital could appropriately be provided at significantly lower cost in physicians' offices and other ambulatory settings. Unfortunately, Medicare and Medicaid, as well as most private insurance plans, encourage hospitalization by (1) paying more for services provided in hospitals than if the same services are provided in a physician's office (for example, Medicare currently pays 100 percent of physicians' charges for ancillary procedures such as X-rays if performed in the hospital but only 80 percent if performed in the office); (2) allowing coverage for some services such as pre-operative evaluations only if provided in the in-hospital setting; and (3) placing high deductibles on services provided in physicians' offices while requiring little or no cost-sharing for in-hospital services.

Consequently, ASIM believes that to create positive incentives for keeping patients out of the hospital, insurers should more equitably reimburse for covered services provided in the physician's office and other ambulatory settings. Third-party payors also should not deny coverage on the basis of location if the setting in which the service is provided is medically appropriate. While there should be some appropriate form of patient cost-sharing regardless of where the service is provided, national policy should discourage punitively high deductibles that discourage patients from receiving services in the ambulatory setting. Since costs associated with hospitalization are the largest components of our health care bill, substantial savings would result from shifting care into physicians' offices and away from hospitals where considerably higher overhead costs (labor, supplies, etc) exist.

2. Develop more efficient methods of reimbursement for in-hospital services.

Medicare, Medicaid and many private insurance plans reimburse hospitals on a "cost plus" basis: hospitals are reimbursed on the basis of costs incurred providing services to patients. Unfortunately, this method encourages inefficiency by rewarding hospitals that generate excessive costs while penalizing hospitals that keep costs down. ASIM has previously testified in favor of provisions in a bill introduced in 1979 that would have created an incentive system for reimbursing "routine hospital costs" under federal health programs. The bill would have classified hospitals according to bed size, type and other criteria; cost would have been determined for each classification through a uniform accounting and reporting system; and a per diem rate for routine operating costs would have been determined for each hospital. Hospitals that stayed within the prospectively determined rate would have been rewarded under this reimbursement method, while those less efficient hospitals that exceeded their per diem rate would have been penalized. Similar legislation has been introduced in the 97th Congress.

ASIM believes that this and other incentive-based approaches to reimbursement for hospital services deserve serious consideration by Congress and private health insurers. ASIM recommends enactment of provisions similar to those proposed in the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979 that would establish an initial incentive system for reimbursement of routine hospital costs under Medicare and Medicaid.

3. Promote patient cost-sharing in private and public health insurance plans.

The popularity of "first-dollar" insurance coverage—which isolates patients and physicians from the economic consequences of their health care decisions—also contributes to health care inflation. Unless patients share in the costs of their medical care, there is no economic incentive for them to question the necessity of any test, procedure or day of hospitalization ordered by the physician—or to limit their own demand for medical services to what is truly needed. Similarly, a physician may be more likely to order tests and procedures of marginal value to the patient when he or she knows the patient will incur no direct out-of-pocket expense.

The current system of first-dollar coverage imposes a severe yet largely unrecognized financial burden on the public in the form of higher premiums for private health insurance and higher taxes to fund public health insurance. Patients are already paying virtually the full cost of care anyway, not only to physicians but to hospitals and other providers as well. Wage increases, too, are being sacrificed as employers increasingly find they can't afford to provide employees with *both* first-dollar health insurance coverage and desired salary increases.

Also because of first-dollar coverage, the patient loses his or her position of privilege attached to the direct payor of the services. First-dollar coverage results in subconscious catering by physicians and hospitals to the whims and tastes of insurance intermediaries instead of patients. ASIM believes that the patient's privileged position should never have been abdicated.

Furthermore, the very fact that first-dollar coverage encourages inefficiency and waste in the delivery of medical services suggests that the *overall cost to the public is higher* than it would be under a system more oriented toward patient cost-sharing. Consequently, ASIM believes that all public and private health insurance policies should include an appropriate degree of patient cost-sharing, in the form of copayment and co-insurance, that would be applied equally to both ambulatory and in-hospital services. Savings resulting from a shift to policies requiring cost-sharing would be substantial, particularly if further studies validate the conclusions of a recent Rand Corporation study that found a 50 percent reduction in health care costs for patients having policies that require cost-sharing compared with patients enrolled in plans providing first-dollar coverage.

ASIM recognizes that the amount of patient cost-sharing must be set at a level that will not discourage patients from seeking necessary services or impose an unacceptable financial burden on the patient. However, the Society is confident that the insurance industry, in consultation with physicians and the purchasers of health insurance, could arrive at an appropriate level of patient cost-sharing.

4. Reduce incentives for expensive technological and procedural care.

The current health insurance system encourages high-cost technological and procedural services, such as diagnostic tests (X-rays, EKGs, etc.), surgery and invasive diagnostic procedures (endoscopic examinations, etc.). At the same time, it discourages physicians from spending more time with patients and providing them with personalized thinking and caring services—the cognitive services a physician provides. This is because procedures are reimbursed at a disproportionately higher level than the more time-consuming thinking and caring services. In addition, many health insurance plans do not cover physicians' cognitive services at all. The result of these perverse incentives is that the *decision to do something* to the patient (i.e., perform expensive surgery or a diagnostic procedure) is rewarded (by higher reimbursement), while the *decision to avoid costly procedures* is penalized (by lower reimbursement).

A physician who spends substantial time talking with the patient, taking a complete physical and history, diagnosing the patient's health problems, evaluating the effects of the patient's lifestyle on his or her health, providing preventive education and finally determining the therapeutic approach that best meets the patient's individual needs will find these cognitive services are reimbursed at a relatively lower level—or not reimbursed at all—by the patient's health insurance policy. However, if the physician orders a series of expensive diagnostic procedures (some of which might be of only marginal value to the patient), it is virtually certain that these procedures will be reimbursed at a disproportionately higher level by the patient's insurance policy. The clinical outcome of these two styles of practice might be the same—but the latter technology-oriented approach is far more costly to the system and, ASIM believes, less satisfying to the patient.

Consequently, the most effective approach to reducing demand for expensive procedural care is to change the health insurance system to reward physicians' cognitive services while discouraging costly procedural services. This can be accomplished by (1) including adequate coverage for physicians' cognitive (thinking and caring) services in all health insurance packages, including Medicare and Medicaid (by providing benefits for office visits, history and physical examinations, preventive education and so forth) and (2) changing the relative amount at which these services are reimbursed, so that cognitive services are reimbursed at a relatively higher level (in line with their true worth) and procedures, at a relatively lower level than is currently the custom.

ASIM has prepared a "White Paper" that explains this problem in greater depth. It is available upon request.

5. Reform costly and ineffective federal regulations.

Many of the federal regulatory initiatives promulgated in recent years have exacerbated rather than contributed to a solution of the cost problem. For this reason, ASIM applauds the efforts of the current administration to reduce unnecessary and ineffective regulations.

Although ASIM acknowledges that some federal regulation of health care is appropriate, federal involvement in areas such as health planning should be limited to supporting and encouraging effective private sector initiatives. Federally mandated health planning in particular has been costly, ineffective and anti-competitive. Nationally imposed guidelines and objectives often have led to regulatory restrictions that in the long run have fueled health care costs. For example, efforts to limit the availability of

CT scans through certificate-of-need (CON) review—an objective of the federal government in recent years—may have actually increased costs by forcing physicians to use more costly surgical procedures in areas where a CT scanner was unavailable because of CON denial.

ASIM strongly recommends repeal of federally mandated health planning and supports continued efforts to review and revise or eliminate other federal regulations that have contributed to higher costs. Available upon request, a summary of existing hard data on the costs and effects of federally mandated health planning has been prepared by ASIM which provides conclusive evidence that the current program is a costly failure.

6. Support and encourage voluntary private sector programs.

Related to ASIM's belief that federal regulatory programs often have been counterproductive is the Society's commitment to voluntary private sector intiatives in areas such as health planning, quality assessment and utilization review. Voluntary, community-based health planning and physician-directed peer review programs can and have been effective, but their effectiveness often has been diminished because of interference, hostility or indifference by the federal government. Federal funding, regulation or review of legitimate private sector activities—or inappropriate federal government use of antitrust laws to limit the ability of health professionals to work together in the public interest—impedes effective private sector approaches to cost and quality control.

Consequently, ASIM recommends that national health policy encourage innovative private sector activities in health planning, quality and utilization review, and cost-effectiveness—with minimal federal funding or regulation. Legislation should be enacted to restrict inappropriate interference by the Federal Trade Commission in the legitimate activities of professional associations, particularly since those activities already are regulated by state law. The recent trend toward formation of coalitions including representatives from business, labor, physicians, hospitals and the insurance industry clearly demonstrates that the private sector can and will work together to reduce costs without federal government coercion or interference.

7. Improve administration of the Medicare and Medicaid programs.

ASIM recognizes the need for the federal government to assure a satisfactory level of care for those who cannot provide for themselves. However, the Medicare and Medicaid programs, although understandably complex, are administered in a manner that promotes inefficiency and waste. Physician and hospital productivity, as well as patient satisfaction, are all adversely affected by the extraordinary paperwork requirements placed on patients, physicians and other providers; by the frequently arbitrary and inconsistent coverage and reimbursement determinations made by individual intermediaries; by the lack of a single coding system for describing physician services under Medicare and Medicaid; by the slowness and difficulty in resolving reimbursement disputes with intermediaries; and by the programs' general resistance to suggestions for improving administrative efficiency. Simply put, the amount of time and resources that physicians and other providers must commit to completing the programs' paperwork requirements and to helping their patients receive adequate reimbursement from Medicare and Medicaid means less time for providing direct patient care—and ultimately higher charges that reflect the substantial administrative costs of participating in the programs. No private insurer could survive today using the complex requirements for reimbursement imposed by Medicare.

Consequently, ASIM recommends that the Health Care Financing Administration (HCFA): (1) appoint a commission to develop recommendations to reduce administrative and paperwork requirements imposed on physicians, patients and hospitals, in consultation with physician, patient and hospital representatives; (2) require nationwide conversion to a single coding system based on Current Procedural Terminology for describing physician services under Medicare and Medicaid; and (3) study ways to minimize reimbursement disputes due to inaccurate or incorrect intermediary coverage determinations and develop recommendations for quicker resolution of patient and physician disagreements with intermediaries.

8. Reduce waste, fraud and abuse in the Medicare and Medicaid programs.

In programs as large as Medicare and Medicaid, it is inevitable that there will be cases of waste, fraud and abuse. ASIM believes that to reduce costs, those contributing factors must be addressed. At the same time, the Society believes that the amount of fraud and abuse is frequently overstated, and that potential savings from attacking fraud and abuse have been widely exaggerated. Furthermore, a reduction in waste, fraud, and abuse will in itself have only a limited impact on overall health care costs, unless it is accompanied by a restructuring of the insurance system to create incentives for cost-effective care.

An effective program to reduce waste, fraud and abuse must include close consultation with practicing physicians. Because of their knowledge of how the Medicare and Medicaid programs work on the grass-roots level, practicing physicians can identify areas of potential savings—as well as effective approaches to reducing fraud and abuse—that may be overlooked by the programs' administrative bureaucracy. ASIM is prepared to offer the expertise and firsthand experience of its members to work with Medicare and Medicaid on the state and local levels in a cooperative effort to reduce waste, fraud and abuse.

9. Expand consumer choice and create incentives to select cost-effective insurance.

Several proposals have been introduced in Congress that would attempt to promote greater competition in health care. Most would expand consumer choice of insurance plans and create incentives through changes in the tax codes for individuals to select more cost-effective plans, i.e., those with cost-sharing features.

ASIM has testified in favor of many aspects of the consumer-choice approach. In general, the Society supports multiple choice of insurance plans (provided that at least one of the plans offered includes significant cost-sharing features), equal employer contributions to all health plans offered, tax-free rebates to consumers who select less-costly plans, and a limit on employers' deductibility of contributions to insurance plans to discourage first-dollar coverage. Those incentives could result in significant cost savings by altering the kinds of insurance that consumers choose. However, since the consumer-choice approach has not been tested in real life, little is known about how much can really be saved and whether or not this approach will have unanticipated negative effects. Some aspects of the proposals currently being considered also could have adverse effects on the quality of medical care.

Consequently, ASIM believes that to the extent possible, the consumer-choice approach should be tested on a demonstration project basis. However, ASIM would support enactment of consumer choice legislation that is based on altering perverse incentives created by tax codes and that includes the principles presented in ASIM's October 1981 testimony before the Ways and Means Committee. A copy of that testimony is available upon request.

10. Promote health counseling and other preventive measures for reducing illness and premature death.

ASIM believes that savings can result from efforts to modify those destructive aspects of an individual's lifestyle that eventually may result in serious and costly illness. Substantial progress in reducing deaths from cardiovascular and circulatory diseases has been made in the last decade, demonstrating the true potential of preventive measures. (It's important to note, however, that successful preventive measures will ultimately result in an older patient population also requiring medical care and generating costs associated with providing that care.)

As noted previously, health insurance rarely covers preventive health counseling and other cognitive services provided by physicians. Ironically, health insurance (including Medicare and Medicaid) spends millions of dollars on medical services for seriously ill patients, but spends little or nothing on services that might have prevented these same costly illnesses.

Because ASIM believes that preventive measures must be supported by the health insurance system, further study of insurance programs that reward patients for staying healthy—by avoiding destructive health habits—are merited. The Society also supports elimination of public policies, such as price supports for the tobacco industry, that promote products proven harmful to health.

ASIM recommends that (1) all health insurance policies provide adequate coverage for physicians' preventive services, (2) studies be initiated to determine the efficacy of insurance programs providing cash incentives for individuals who stay healthy and avoid destructive health habits, and (3) federal price supports for tobacco products and other federal and state programs that economically support and promote products proven harmful to health be identified and eliminated.

Summary and Conclusions

In summary, ASIM urges adoption of a national incentive-based health policy that:

1. Creates incentives for providing services in ambulatory instead of in-hospital settings by (a) reimbursing more equitably for services provided in the ambulatory setting (b) discouraging insurers from placing punitively high deductibles on services provided in the ambulatory setting, and (c) discouraging insurers from denying reimbursement for covered services on the basis of the setting in which the service was provided (as long as the setting is medically appropriate).

2. Develops more efficient methods of reimbursement for services provided in the hospital by (a) enacting a prospective reimbursement system under Medicare and Medicaid for routine hospital costs and (b) studying on a demonstration project basis other incentive-based approaches to hospital reimbursement.

3. Promotes appropriate patient cost-sharing in the form of copayments and co-insurance as a feature of all private and public health insurance plans.

4. Reduces incentives for expensive technological and procedural care by (a) including coverage in all insurance packages for physicians' cognitive services and (b) changing the relative amounts at which these services are reimbursed so that cognitive services are reimbursed at a level that recognizes their true value to the patient.

5. Reforms costly and ineffective federal regulations by (a) repealing the federally mandated health planning program and (b) continuing efforts to review, revise or eliminate other federal regulations that have contributed to high costs.

6. Supports and encourages voluntary private sector programs in health planning, cost-effectiveness and quality and utilization review by (a) minimizing federal interference in private sector activities and (b) enacting legislation to restrict the inappropriate use of antitrust laws by the Federal Trade Commission to prevent or impede the development of cooperative private sector activities.

7. Improves the administration of the Medicare and Medicaid programs by (a) creating a commission charged with assigning high priority to reducing administrative and paperwork requirements imposed on physicians, patients and hospitals, in consultation with physician, patient and hospital representatives, (b) requiring nationwide conversion to a single coding system for describing physician services based on Current Procedural Terminology and (c) studying and developing ways to minimize reimbursement disputes due to inaccurate or incorrect intermediary determinations and ways to more quickly resolve such disputes.

8. Reduces waste, fraud and abuse in the Medicare and Medicaid programs through a collaborative effort between the Health Care Financing Administration and physicians.

9. Expands consumer choice of insurance plans by creating incentives for the selection of more cost-effective plans through enactment of legislation that would expand choice of insurance plans and alter tax laws to discourage over-insurance.

10. Promotes health counseling and other preventive measures to reduce illness and premature death by (a) encouraging health insurers to provide adequate coverage for physicians' preventive services, (b) studying the efficacy of insurance programs that provide economic incentives for individuals to stay healthy by avoiding destructive health habits and (c) identifying and eliminating federal price supports for tobacco products and other federal and state programs that support or promote products proven harmful to health.

ASIM believes that restructuring the health care system along the above lines would not only be effective in moderating health care costs, but would also provide the public with the kind of health care system desired: an affordable, high-quality system encouraging personal, caring, preventive primary-care services in physicians' offices instead of expensive, impersonal, technology-oriented care in hospitals. ASIM is providing these recommendations to the Reagan administration, Congress, health insurers, business and labor groups, the AMA and other physician organizations, hospitals, state governments and other interested groups. The Society challenges each of those groups to work with ASIM on implementing the above and other recommendations for a national incentive-based health policy.

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Mr. **Anthony.** Mr. Gradison.

Mr. **Gradison.** Thank you, Mr. Chairman. No questions.

Mr. **Anthony.** I have a couple of inquiries.

I guess the point of the acting chairman is to play devil's advocate, so I will assume the role of what I think the chairman would ask had he had the opportunity to be here in person.

To the AMA, I wonder if you can give us any details that you are presently taking under consideration for long-term solutions to the health care cost increases?

Dr. **Felch.** Mr. Chairman, I——

Mr. **Anthony.** A followup question would be, if and when could we expect to have some of those details submitted to the committee?

Dr. **Felch.** Thus far the determination has been to make the study of national health policy and a process has been set up for making that study consisting of a number of task forces, the involvement and participation of other bodies, both in the private and public sector; the deliberations of those task forces and testifiers filtering up into a national steering committee at which time specific recommendations will be made.

It is contemplated that the whole process may take as much as 24 months, but we hope that some parts will take considerably less than that.

The notion is now that some segments of the study may perhaps turn out to be easier and specific proposals could be developed within the first 6 or 8 months perhaps, and submitted to you and others for your consideration at that time.

Mr. **Anthony.** I think what you have just pointed out is the dilemma we find ourselves in.

Any detailed examination of a complex field is going to require some time, yet, because of budget constraints and laws passed last year and possible laws being passed this year, we are going to be faced with some short-term problems.

Two things bother me on the statement of the American Medical Association. I just want to toss out some things that are going through my mind.

Quickly going through the list of things that you have put in the back of your statement, I notice that the majority of them, if not the overwhelming majority of them, deal with cost areas other than physicians directly.

I guess I could understand that.

There are at least two other proposals submitted by the administration. One has been billed as the economic increase limit to 5 percent which has very substantial savings when added up over a period of time.

Then second is revision of medicare fee screens October 1, rather than July 1.

That one calculates out even much higher, $220 million in fiscal year 1983 going upward on through 1987.

I just wondered, are you rejecting those today in that they are not part of your list in the back of your testimony?

Dr. **Felch.** We have tried to make our list consist of possible things that could be done that conformed with AMA policy. Those two items that you mentioned do not conform with AMA policy.

They were discussed within the decisionmaking bodies of AMA and turned down.

The feeling was that hospitals are where the action is to a considerable economic degree. The other being that hospitals may have had it rather easy through cost-based reimbursement over the course of the years since 1965, whereas the usual customary and reasonable fee concept has been under attack and constraints by Congress and the executive branch ever since 1966.

Doctors tend to perceive that the original UCR notion has been distorted and beaten out of shape over the years. I am afraid that is why so many doctors only take assignments for particular kinds of their patients. That is why those two items are not on our list.

Mr. ANTHONY. On page 8 of your testimony is the other thing that immediately jumped to mind as you gave your testimony.

Talking about trying to get away from cost shifting into cost savings, yet, a careful analysis I would suspect of indexing the medicare part B deductible actually is a cost shift and not a cost savings.

More particularly, if we followed your recommendations that a more accurate indicator of the increases be used rather than the CPI, I would assume that a more accurate indicator than the CPI would be a higher index, rather than a lower index.

Is that a fair assumption?

Dr. FELCH. Not necessarily. We think a fairer index would be the cost within the CPI of medical care services, particularly physician services.

Over the years that has sometimes been higher than the whole CPI, sometimes lower than the whole CPI.

Mr. ANTHONY. OK.

Dr. FELCH. As far as your first question is concerned, you are right, almost every item I have heard discussed today in a sense can be considered to be cost shifting and our statement gives the general principle it should be recognized and avoided to the degree possible, but when you come to the nitty-gritty of having to make specific concrete proposals, you end up making proposals that will cause some degree of cost shifting.

I agree.

Mr. ANTHONY. Have there been any proposals submitted in the Congress as far as you know or through policy of either one of your organizations that would limit the total dollars that any one physician could receive through medicare payment?

Dr. FELCH. No.

Mr. ANTHONY. A cap, so to speak?

Dr. CONNALLY. I know of none.

I think the proposal that I made that physicians' cognitive services be increased at a relatively faster rate than procedural services would probably cut down some of the high rollers. It would be almost impossible for a physician who was reimbursed only for spending time talking to and examining patients to have extremely high income.

The doctors who really are making these at times obscenely high amounts of money are people who rely on procedures and are inappropriately utilizing laboratory tests.

Mr. ANTHONY. How do you think the medical society would react if an amendment were offered to put on a cap, say a couple hundred thousand dollars?

Dr. FELCH. I have never heard that discussed within the halls of the AMA.

We would probably react adversely to it; that it was contrary to American constitutional principle.

Mr. ANTHONY. In what sense, in that one should be allowed to earn as much as one could?

Dr. CONNALLY. A lot of medical societies right now have their own peer review, which is stimulated by insurance companies, by medicare, or in some instances, providers of medicare services. If a physician has collected a huge amount of money, that rings the bell on the computer and the fee or peer review mechanism within the medical societies comes into play. I think that the medical societies would take a hard look at that kind of thing.

Part of it would depend on how it was administered, where the line was set.

Mr. ANTHONY. So then, I take it, you would support action by the Congress to remove self-imposed restraints on our tax exemption, business expenses? It is kind of the same theory.

It looks like that issue is going to rise again.

On page 4 of your testimony, Dr. Connally, I wanted to make a comment, and you brought it up.

Do you see within the profession what you would consider to be abuses by the fact that doctors are calling for, and are actively engaging in, some of these higher and more technological procedure care areas?

Dr. CONNALLY. Yes.

Mr. ANTHONY. That is at least an abuse we ought to take a closer look at.

Dr. CONNALLY. Yes, sir.

Mr. ANTHONY. You are recommending a way to curb it. I think you are to be commended for bringing it to our attention and even offering a suggestive way of correcting it.

Dr. FELCH. The profession would like to do something about the high rollers in our midst, and the people who are charging excessively or making excessive incomes.

Mr. ANTHONY. Would not the cap do that?

Dr. FELCH. How about getting the FTC off our back, and letting the profession try to do it on its own for a while?

Mr. ANTHONY. I would be for that, if it would work.

I want to thank both of you for coming in. You have given valuable testimony to the committee, and we look forward to working with you as we try to come up with some simple solutions to a complex issue.

With that, the subcommittee will adjourn until the call of the Chair.

[Whereupon, at 3 p.m., the hearing was adjourned.]

[The following material was submitted for the record:]

STATEMENT OF FRANCES KLAFTER, COCHAIRMAN, NATIONAL HEALTH TASK FORCE, GRAY PANTHERS

I was out of the city when these hearings were held, but appreciate this opportunity to submit this statement for the record.

The Gray Panthers have long been shocked at the wide gap between the promise of Medicare, as ennunciated by then President Johnson, when he signed the Medicare bill of 1965: "* * * no longer will older Americans be denied the healing miracle of modern medicine * * * no longer will illness crush and destroy their savings * * *", and the reality of it—that even today, without the frightful cuts in the program proposed in the budget resolution for 1983 passed by both Houses of Congress, Medicare pays less than 40 percent of the total health care costs of Medicare beneficiaries.

Our opposition to these cuts was set forth in my letter to you of April 26, 1982, and I will not repeat here the points we raised at that time, as they have been adequately covered by witnesses at these hearings. I am addressing in this statement only one aspect of the proposed cuts—the proposal to limit reimbursement to providers under Medicare Part B, which, of course, means increasing the amount beneficiaries must pay out of their own pockets.

We believe that the only way to contain health care costs is to reduce providers' fees at all levels. We do not agree that anything is being done to reverse the inflation in health care costs simply by cutting the amount the Federal Government pays out to health care providers and shifting the cost to beneficiaries of Federal programs.

We do believe that charges at all levels can be brought down, by firm public measures for hospital cost containment and, if not by law, by concerted consumer action to reduce charges for out-patient health care services.

For this reason, in early 1981 the Gray Panthers decided to undertake to organize a national Medicare Assignment campaign. This followed the publication by the Public Citizen Health Research Group of Your Money or Your Health: A Senior Citizens' Guide to Avoiding High-Charging Medicare Doctors. The author, Daniel W. Sigelman, had obtained information for this analysis of fees charged Medicare beneficiaries by certain specialists in the Washington metropolitan area directly from the Medicare insurance carriers (at that time Medical Services of the District of Columbia), under the Freedom of Information Act, with a waiver of fees.

The Health Research's Group's accomplishment in establishing the public's right to information about doctors assignment practices from Medicare records, and the subsequent analysis published, were hailed by the leaders of all of the organizations particularly concerned with problems of the elderly, but the response of the Gray Panthers was to organize for action. So the Gray Panthers decided to follow up immediately on the Health Research Group's success in the Washington area. Whereas the HRG report covered only some providers under Medicare Part B, and the data were for 1978, the Gray Panthers of the Metropolitan Washington area (the District of Columbia, Montgomery County and Northern Virginia—Prince George's Gray Panthers were not yet organized) requested information for 1980 (the latest year available at that time) on the Medicare assignment practices of all providers under Medicare Part B in the area.

The success of the directory which was subsequently issued and the importance of such consumer undertakings in the fight to contain health care costs is exemplified in the news stories which follow from the Washington Post of April 21, 1982 and the Gray Panther Network for May-June 1982.

[From the Gray Panther Network, May-June 1982]

METRO D.C. PANTHERS PUBLISH CONSUMER GUIDE

Washington, D.C.—In an effort to guarantee older people access to affordable, quality health care, the Gray Panthers of the Metropolitan Washington area and a coalition of other area groups have published a consumer guide detailing Washington area physicians who accept Medicare assignment rates and their billing practices.

The directory was released at a press conference April 20, held at the U.S. Capitol. National Gray Panther Convener Maggie Kuhn, Oregon Congressman Ron Wyden, a member of the House Select Committee on Aging and former convener of the Oregon Gray Panthers, and Frances Klafter, co-chair of the Gray Panthers National Health Task Force, addressed the conference.

Leaders of the local Gray Panters and of the organizations which compiled the directory also participated.

The Medicare assignment directory entitled, Does Your Doctor Take Medicare Assignment?, lists an estimated 6,000 doctors according to their specialty, the jurisdiction in which they practice and the percentage of Medicare cases they accepted on assignment in calender 1980.

"We feel this self-help resource for consumers and the elderly," said Frances Klafter, who helped compile the directory, "is an important part of the national effort to contain health care costs." "The Gray Panters are combining this effort with an active campaign against the administration's proposal to reduce reimbursement rates under Medicare Part B, as well as other proposed cuts in Medicare."

The "Introductory Notes" to the directory states it is "being issued because we believe that doctors' fees are higher than many Medicare beneficiaries can pay and that access to health care for this group is thus limited.

"Because health care costs are a matter of life or death for many people—and for many more, a matter of health or ill-health—we consider the national fight for health care cost containment one of the most basic aspects of the fight against inflation. The vigor with which this fight has been carried on officially has varied from one national administration to another, but certainly its most prominent current characteristic is the attempt to contain government health care expenditures—not over-all health care costs—by limiting the access to health care of beneficiaries of various federal programs, including Medicare, by raising co-payments and deductibles and decreasing benefits."

Information in the book is based on actual Medicare claims processed for Washington area physicians and obtained by the Coalition for Reducing Medicare Doctor's Charges from Medicare records under the Freedom of Information Act.

The conference received excellent coverage including a lengthy article in the Washington Post.

Each Copy sells for $2 and may be ordered from Metro D.C. Gray Panthers, 755 Eighth St. NW, Washington, D.C. 20001.

[From the Washington Post, Apr. 21, 1982]

GRAY PANTHERS RELEASE GUIDE TO THE AREA'S MEDICARE DOCTORS

(By Molly Sinclair)

A consumer guide designed to help the elderly locate Washington area physicians who accept Medicare assignment rates and billing practices was released yesterday by the Gray Panthers, the activist senior citizens organization, and a coalition of other groups and individuals.

The guide lists an estimated 6,000 doctors according to their specialty, the jurisdiction in which they practice and the percentage of Medicare cases they accepted on assignment in calendar 1980.

"We want people to use the directory to find a physician who will take Medicare assignments," said Frances Klafter, a Gray Panther official who helped compile the guide.

In accepting Medicare assignment on a patient, the physician agrees to accept the payment rate that has been determined by the goverment to be the "reasonable charge" for services performed for that patient. Medicare then reimburses the physician for 80 percent of the established "reasonable" payment, and the patient is responsible for the rest after satisfying the annual $75 deductable.

When a physician doesn't accept Medicare assignment, the patient becomes responsible for all charges imposed by the physician. He still may be eligible to recover Medicare benefits up to the 80 percent cap. But that cap is for 80 percent of the established "reasonable" fee established by Medicare rather than 80 percent of the physician's actual fee.

At a press conference yesterday, coalition leaders said that the guidebook is an important part of their national campaign to contain health care costs and to defeat administration proposals to reduce Medicare benefits.

"* * * we believe that doctors' fees are higher than many Medicare beneficiaries can pay and that access to health care for this group is this limited," the coalition said in the directory's introductory notes.

Klafter said price shouldn't be the only consideration, however, when consumers seek medical help. "They should inquire if this is the doctor who will best suit their purposes and their needs," she said.

Information in the book is based on actual Medicare claims processed for Washington area Physicians and obtained by the Coalition for Reducing Medicare Doctors' Charges from Medicare records under the Freedom of Information Act.

The coalition, which is made up of the Gray Panthers of Metropolitan Washington, 21 other area organizations and more than 50 individuals, has published 2,000 guidebooks for distribution to individuals and groups. Each copy sells for $2—the amount the coalition said it needs to recover the cost of printing, postage and other expenses—and may be ordered from the Gray Panther offices. 755 Eighth St. NW, Washington, D.C. 20001.

The District of Columbia Medical Society declined to comment on the guidebook since officials there hadn't seen it. But Dr. Edward E. Fitzgerald, the society's president, questioned the need for such a guidebook.

"There is a better way to arrive at that information." Fitzgerald said, and that is to ask the doctor's office directly.

Fitzgerald said the doctor's decision typically depends on the patient's financial standing. "If I think there is a question of financial hardship, I take assignment. If I don't feel there is financial hardship, I do not accept assignment. That is the official policy in my office and I have reason to think many other follow the same policy."

According to the coalition's guidebook, 161 Medicare claims from Dr. Fitzgerald's office were processed during 1980. Of that total, 13 percent were cases on assignment. Dr. Fitzgerald said that those numbers appeared to be accurate.

Percentage of cases taken on assignment varied enormously from one physician to another, however. Some took 100 percent assignments; others took none on assignment. Many fell in between those two extremes.

Consumer interest in this undertaking is spreading and we are now exploring a much broader national campaign in coalition with other national organizations concerned with health care cost containment.

A difficulty in pursuing this project nationally is that, although the Health Care Financing administration, in making data available on the two occasions cited above, has recognized that the availability to the public of the data necessary for compiling a "Medicare Assignment Directory" is in the public interest, and fees for it should be waived under the Freedom of Information Act, several groups in different parts of the country have now been told by HCFA representatives that the data will no longer be made available to consumers.

We feel that in the long run the impact that this project could have on doctors fees would spread far beyond the Medicare program and would affect over-all health care costs. We think it very short-sighted for the federal government to thwart the efforts of consumers to reduce fees charged them by health care providers, and would welcome the intervention of your committee with the Department of Human Services to assure that Medicare beneficiaries and their representatives can have access to the information they need to attempt to reduce Medicare doctors' charges.

Enclosed for your information, but not intended, of course, for the record are copies of a guide we have issued, "How to Organize A Medicare Assignment Campaign," and "Does Your Doctor Take Medicare Assignment?" which is the Directory issued by the Metropolitan Washington Gray Panthers.

It goes without stressing the point, of course, that the efforts of consumers to persuade doctors to charge no more than the so-called "reasonable charges" set by Medicare will be greatly weakened, if not made hopeless, if the proposal to limit provider reimbursements under Medicare Part B were to be included in the Medicare legislation for 1983. We hope that your committee will successfully oppose this proposal.

BETHESDA, MD., *June 14, 1982.*

Hon. ANDY JACOBS, Jr.
Chairman, Subcommittee on Health,
Committee on Ways and Means, Washington, D.C.

DEAR MR. CHAIRMAN: In response to your news release of June 8, I submit for your subcommittee's record the following articles that describe several proposals aimed at producing significant and fundamental reform in the Medicare program:

(1) "Challenges in the New Era of Competition," in Issues in Health Care, Volume III, No. 1 (Laventhol & Horwath, 1982),

(2) "Medicare vouchers—the concept and the issues," in Hospital Financial Management, Vol, 36, no. 1 (HFMA, January 1982),

(3) "Largest Competitive Health Program Faces a Crisis," in Hospital Financial Management, Vol. 36, no. 3 (HFMA March 1982), and

(4) "Is Consumer Choice and Competition in Health Care the Wave of the Future?" in Hospital Financial Management, vol. 34, no. 11 (HFMA, November 1980).

In each of these articles, opportunities are described that would cut costs without cutting the quality of health care services. I hope that you and your colleagues on the Ways and Means Committee will examine these articles as you seek to find ways to produce not only immediate but also long-term savings in the Medicare program.

If I may be of further assistance to you, please feel free to call on me * * *.

Sincerely,

WALTER J. UNGER.

[Enclosures have been retained in the subcommittee files.]

STATEMENT OF UNITED SOCIETIES OF PHYSIOTHERAPISTS, INC,. PREPARED BY ALAN LEVENTHAL, P.T., NATIONAL LEGISLATIVE CHAIRMAN, AND JOHN MACKO, ESQ., LEGISLATIVE COUNSEL

Mr. Chairman and distinguished members of the Subcommittee, we are pleased that Chairman Jacobs has called these hearings on proposed budget cuts affecting the Medicare Program. We are grateful for the opportunity to present this written testimony and we hope to persuade you to enact changes in the Medicare Law which, by increasing competition among providers, will produce significant and fundamental reform in the Medicare Program. We firmly believe that if competition among providers is increased, the total cost to the Medicare Program will be reduced significantly.

As you are aware, Public Law 96-499 (the Omnibus Budget Reconciliation Act of 1980) enacted significant changes in the Medicare Law with respect to physical therapy. The Medicare Program, as amended by Public Law 96-499, provides coverage of physical therapy services as follows:

> (1) All physical therapy services rendered while a patient is in a hospital by a therapist in the employ of the hospital are covered;
>
> (2) All outpatient physical therapy services are covered if they are provided as part of the treatment program given by a physician, a hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency or public health agency participating in the treatment program;
>
> (3) Only $500 per year of physical therapy services are covered if the services are rendered by a private physical therapist. (Prior to the passage of Public Law 96-499, the limit was $100).

As we will show, Mr. Chairman, the current law discourages competition and encourages the elderly patient needing physical therapy to use the highest cost provider of the service because it is covered under Medicare while lower cost providers are not covered to the same extent. Medicare coverage differs not based upon a difference in the services which are provided, but simply because of a difference in the setting in which the services are provided. Given the same physical ailment and the same kind of treatment, and often the same therapist, the patient's right to reimbursement differs drastically depending upon where the treatments are provided.

While these distinctions are not arbitrary, neither were they designed to optimize the availability of quality care, nor to minimize the cost to the taxpayer. These discriminatory provisions of the current Medicare Law accomplish neither of these admirable goals.

Current law, in essence, limits patients needing physical therapy at home to obtaining those services only through the auspices, and with the added overhead costs, of certified home health agencies. This is the result of providing an unlimited number of home health visits, while restricting home visits by a private physical therapist to $500 per year. Similarly, the ambulatory patient needing physical therapy is encouraged to use a hospital outpatient clinic because of the unlimited services provided, while coverage of the services of the private practitioner is limited to $500 per year.

The settings for care which are encouraged by the Medicare reimbursement system are almost always more costly for the taxpayer. Fees paid to physical therapists working "under arrangement" with approved providers are regulated by the Department of Health and Human Services and are generally in line with fees charged by private practitioners in the same locality. However, the government pays more for services rendered by "providers" who always add administrative overhead costs to the base rate charged for physical therapy.

For example, a survey in Brooklyn, New York revealed the following: at Long Island College Hospital, the fee paid to the physical therapist was $20, the fee paid to the agency employing the therapist was $55. At Brooklyn Hospital, the fee paid to the physical therapist was $15, the fee paid to the agency was $25, and so on down the line. The cost to the government for these services is two to three times higher than if Medicare had paid the physical therapist directly or reimbursed the patient as they do in the case of other licensed health professionals, such as physicians, podiatrists, optometrists, etc. The difference between the amount paid to the institution and the amount received by the physical therapist is due to the administrative costs of the provider system - a cost either non-existent in the private practice setting or absorbed by the private physical therapist.

Further, in a GAO Report issued May 15, 1979, entitled "Home Health Care Services - Tighter Fiscal Controls Needed", the costs of physical therapy and other services delivered by eleven home health agencies in Louisiana and Florida were discussed.

GAO found that per visit charges for physical therapy care delivered by such agencies in high-cost metropolitan areas ranged from a low of $9.18 to a high of $63.20. GAO did not have data which would show the average of the charges covered by the study. The GAO noted that the major reason for the variances was the excessive administrative and clerical costs in some agencies. It also noted that some agencies were overstaffed.

Since Medicare essentially allows for the reimbursement of all "reasonable" costs related to patient care, these administrative costs are passed on to the taxpayer. Unfortunately, the GAO data was not national in scope and since the GAO report was based on 1976 data, costs are undoubtedly much higher today. However, it is the only detailed government data on the cost of physical therapy available. (A summary of the GAO Report is attached as Appendix "A").

On March 31, 1981 we had the privilege and opportunity to testify before this Subcommittee. At that time and on previous occasions when we testified we cited the lack of available cost data. The Committee on Ways and Means in its Report on the Medicare Amendments of 1979 wisely requested the Secretary of Health and Human Services

> ...to collect and submit data on the costs of physical therapists in independent practice. The Committee also expects that in submitting such data, the Secretary would include national comparisons of costs for physical therapy services furnished by independent practitioners and the cost of such services when provided in all other settings covered under the Medicare Program. (Report 96-588, Part I, Page 22, November 1979).

Unfortunately, this study, to our knowledge, has not been conducted and may not even have been initiated as of this date.

Because of the lack of cost data, the United Societies has attempted to collect cost data on the average cost of a visit to an institutional provider and to a private practitioner. Because of our limited financial resources we were able to study only one regional area (the six county Rochester, New York region). We conducted two separate studies. The first study, conducted in preparation for our testimony at the June 27, 1979 hearings, used Blue Cross/Blue Shield data for the Rochester region. We examined all Blue Cross/Blue Shield outpatient physical therapy claims (9,561 claims) for the region for the preceding eighteen month period. The data revealed that the average cost of a visit to an institutional physical therapy facility was $61.64. In contrast, the average visit to a private physical therapist cost approximately $20. In the second study, more extensive data was gathered which further demomstrated the savings potential possible through expanded use of private physical therapists. In the Rochester, New York area cost data was gathered for 14,360 physical therapy visits for the period from January 1, 1978 to June 1, 1980. This data represents every physical therapy treatment provided by an institutional provider and paid for by Blue Cross/Blue Shield. This data base, although somewhat dated, is still one of the most comprehensive available anywhere on the subject. The data shows that the average cost of a visit to an institutional provider for this period was $62.81. Again, in contrast, the average cost of a private physical therapy treatment was approximately $20. This data base confirms the fact that an institutional physical therapy visit is, on the average, three times as expensive as a visit to a private therapist.

However, as stated earlier, current Medicare Law often forces the elderly patient to choose the higher cost institutional provider because most, if not all, of the treatments will be covered by Medicare if rendered by the institutional provider. Current law, therefore, penalizes both the patient and the Medicare Program. The Medicare Program is burdened by much higher costs. The patient is restricted in his choice of a physical therapist, which may result in reduced patient satisfaction and, perhaps, reduced quality of care.

The recently enacted provisions of Public Law 96-499 allow a patient to be reimbursed for the first $500 of private physical therapy care and will permit a patient, in many instances, to be treated by a therapist of his choice. This should result in the patient choosing to switch from a higher cost institutional provider to a lower cost private practitioner at a considerable savings to the Medicare Program.

We believe that there will be a significant shift from the higher cost institutional provider to the lower cost private practitioner. There are few areas where the relationship between patient and treating professional is as personal and as time consuming as that bewtween a patient and his physical therapist. A therapist, with whom an arthritic patient or stroke victim has developed a relationship of trust, can do far more to help the patient than a stranger.

However, when the elderly patient arrives at a public clinic for treatment, he has no guarantee that he will see the same physical therapist each time. In all likelihood, it will be a stranger. The patient must "re-educate" the physical therapist concerning his particular needs and requirements. In fact, until the new physical therapist learns the needs of his patient, this education process may be physically painful to the patient. This possibility of needless physical pain and psychological trauma faces the elderly patient each time he goes for treatment. As a result, many elderly patients, if given the option, will, Mr. Chairman, surely choose to go to a private physical therapist rather than an impersonal clinic. This shift will occur at a cost savings to the Medicare Program.

If we assume that 20% of the patient visits for physical therapy treatment (out of an assumed total of one million) shift from institutional providers to private practitioners, we would see a net savings of $42.81 per shifted treatment ($62.81 per institutional treatment versus $20 per private treatment) or $8.6 million. This conclusion is based on very limited data. However, all the data available, form private sources, GAO and HHS, supports this conclusion.

The new law has only been in existence since January of this year and the extent of the shift cannot, of course, be predicted with any precision at this time. However, we believe that the shift may be much greater than 20%. In addition, Mr. Chairman, your Subcommittee can encourage the shift from higher cost providers to lower cost providers. One mechanism that would surely encourage the voluntary selection of the lower cost provider is to impose comparable limits on all providers of physical therapy services. Currently, there are no limits on the higher cost providers, and very severe limits on the lower cost providers. This would appear to be exactly the opposite of what common sense would indicate. If comparable limits were imposed, this would surely lead to increased competition between providers and lower total Medicare costs.

For example, comparable limits could be established which limit the annual number of treatments, i.e. visits, to which a patient is entitled -- independent of who provides the treatments. If desired, specific limits could be established by type of ailment, e.g., a patient suffering from a hip fracture may be entitled to a total of 60 treatments -- independent of who provided the treatments.

Alternatively, the limits could be expressed as a total number of visits per year per patient (an annual limit of 100 visits would cover all but the most serious situations -- See Appendix "B").

Currently, institutional providers are not subject to any such limit. The private physical therapist is subject to an annual limit of $500 which covers approximately twenty treatments. Currently, at least in theory, a patient could receive an unlimited number of treatments in a hospital, followed by an unlimited number of treatments from an outpatient clinic or home health agency and still be eligible for up to $500 of treatments from a private therapist. By establishing overall visit limits, competition between providers will be increased and total costs will be reduced.

CONCLUSIONS

In summary, we urge you today to adopt measures which will encourage our elderly to voluntarily choose the lower cost provider of physical therapy because it is in their best financial and health interests. We have suggested an approach. It is revolutionary and will result in significant reform and lower costs for the Medicare Program.

We are not unaware that the Administration has again proposed the elimination of the $500 limit. We have testified before you previously on this subject and we appreciate your past support. Repeal of the $500 limit would restrict the ability of the elderly patient to choose the lower cost provider and would be false economy. As your are aware the Senate Finance Committe has already rejected this proposal.

Rather, we urge you to adopt fundamental reforms in the Medicare Program regarding physical therapy. We believe that the American public deserves a better system of physical therapy care than the one now part of the Medicare Program. The approach we recommend would be far superior -- and yet less costly. We urge you to give it serious consideration. We stand ready to assist in all possible ways.

[Attachment]

(Excerpted from GAO Report)

APPENDIX "A"

CHAPTER 2

HOME HEALTH CARE COSTS VARY GREATLY

The cost of providing home health care varies greatly throughout the country. For example, for the eight agencies we reviewed in Florida the average cost claimed for a home health visit in fiscal year 1976 ranged from $16.61 to $33.26. Wide variances in unit costs can be explained by a number of factors, and they frequently are a function of utilization. But we have found that a major reason for the variances is that some agencies incur excessive administrative and clerical costs and may be overstaffed.

Medicare essentially allows reimbursement for all costs claimed by home health agencies so long as the costs are found to be related to patient care, reasonable, and not substantially out of line with comparable agencies. In past years these terms have not been defined, but in March, 1979 HCFA published in the Federal Register proposed reimbursement limits for home health services by type of visit.

A NATIONWIDE PROBLEM

The amount of Medicare reimbursement for home health care varies widely across the country. Examples of such variances are the costs reimbursed for home health care in high-cost metropolitan areas such as Miami, Boston, New York, Chicago, LasVegas and Los Angeles. The table below summarizes the range of these variances.

Range of Medicare Reimbursement for Home Health Care in High-Cost Metropolitan Areas by Type of Visit and Agency Workload for Fiscal Year 1976 (Note A)

Type of Visit	Agency Workload (Visits Made)			
	1-4,999	5,000-9,999	10,000-19,999	20,000+
Physical Therapy:				
High	$57.42	$63.30	$40.26	$52.92
Low	9.18	10.00	9.63	12.29
Skilled Nursing:				
High	79.19	55.62	35.00	42.72
Low	4.56	5.79	8.95	14.43
Home Health Aide:				
High	33.27	30.54	31.25	34.72
Low	3.41	5.44	4.85	6.69

MANAGEMENT AND CLERICAL COSTS

We noted wide variances in the costs of performing various management and clerical activities. As shown by the following table, the costs had little or no relationship to the number of patients served or visits made:

Average Management and Clerical Costs
By Patients Served and Visits Made
Fiscal Year 1976

Agency (Note A)	Cost	Patients Served	Visits Made	Average Cost By Patients Served	Average Cost By Visits Made
Florida:					
Dade County	$310,400	2,009	46,670	$154.50	$6.65
Home Health	299,100	1,000	42,626	299.10	7.02
Hollywood	246,700	697	27,440	353.95	8.99
Bay Area	226,400	2,277	56,020	99.43	4.04
Broward County VNA	132,600	2,104	40,844	63.02	3.25
Pinellas County	118,600	892	23,503	132.96	5.05
Medi-Health	107,600	710	20,926	151.55	5.14
Hillsborough VNA	47,600	1,442	22,251	33.01	2.14
Louisiana:					
HHS/Louisiana	291,400	905	43,212	321.99	6.74
Capitol	212,600	704	33,109	301.99	6.42
Golden Age	129,000	1,006	46,699	128.23	2.76

A/ See Appendix I for the complete agency name.

During fiscal year 1976 Dade County, a nonprofit Medicare only provider, had 16 full-time equivalent administrative and clerical employees that received over $208,000 in wages and benefits. During this same period, the agency also purchased substantial administrative services from other organizations. Purchased services included $60,948 for management, accounting, and data processing services, $39,868 for typing services, and $1,620 for board meeting expenses -- bringing total management and clerical costs to about $310,400, the highest of all the agencies reviewed. By comparison, the Broward County VNA -- which is about 20 miles away -- served about the same number of patients and made about the same number of visits, but it incurred approximately $132,600 in similar administrative costs -- a difference of $177,800 from Dade County.

(End of Excerpted GAO Report)

APPENDIX "B"

COMMON AILMENTS OF THE ELDERLY

Ailments of the elderly often require physical therapy treatment. Physical therapy encompasses a wide variety of treatment techniques or "modalities" as they are called within the profession. One or a combination of modalities may be used depending on the particular condition being treated. Patients having the same ailment may require different modalities depending on the individualized problems encountered. The modalities commonly utilized include, among others, various types of heat therapy, hydrotherapy, electrotherapy, as well as ultra sound, therapeutic exercise, massage, traction, gait training, and testing and evaluation procedures. The following paragraphs discuss some of the more common ailments of the elderly which require physical therapy treatments.

HIP FRACTURES

(1) Intertrochanteric Fracture of Femur - A bone fracture near the upper extremity of the femur.

(2) Subcaptal Fracture of Femur - A bone fracture just below the head of the femur.

(3) Joint Replacement - The implanting of an artificial joint to replace a severely damaged joint.

***For these three ailments physical therapy is required to relieve muscle strain, restore range of movement, and develop proper gait and weight bearing.

STROKE - A stroke often affects a person's ability to exercise conscious control over muscles, and, therefore, affects the ability to consciously control the movement of an arm, leg, etc. Balance, and therefore the ability to walk, is often affected. Therapy is needed to restore these functions.

CERVICAL RADICULITIS (pinched nerve) - Inflammation of a nerve route caused by compression of the nerve canal resulting in neck pain, stiffness, weakness, and numbness in the affected extremity.

LOW BACK PAIN - Therapy is needed to lessen persistant pain, spasm, and disability. One type of low back pain is sciatic neuritis.

ADHESIVE CAPSULITIS (frozen shoulder) - Swelling of the membrane around a joint or connective tissue causing painful and restricted movement. Therapy is needed to restore free movement and reduce painful inflammation.

ARTHRITIS - Therapy is required to reduce stiffness and pain, improve function, and in some cases to help the patient adjust to restricted movement.

RANGE OF NUMBER OF PHYSICAL THERAPY TREATMENTS REQUIRED BY TYPE OF AILMENT

AILMENT	# OF PHYSICAL THERAPY TREATMENTS (RANGE)
Hip Fractures	
(1) Intertrochanteric Fracture of Femur	40-80
(2) Subcaptal Fracture of Femur	40-60
(3) Joint Replacement	30-40
Stroke	5-200+
Cervical Radiculitis	10-40
Adhesive Capsulitis	10-40
Sciatic Neuritis	5-25
Arthritis	10-40